

**Introduced by Senator Alquist**February 24, 2012

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An act to amend Section 100185.5 of the Health and Safety Code, and to amend Sections 14043.2, 14043.65, 14043.75, 14107.11, 14123.05, and 14409 of, to amend, repeal, and add Sections 14043.1, 14043.15, 14043.25, 14043.26, 14043.28, 14043.36, 14043.4, 14043.55, and 14043.7 of, and to add Section 14043.38 to, the Welfare and Institutions Code, relating to Medi-Cal.

## LEGISLATIVE COUNSEL'S DIGEST

SB 1529, as introduced, Alquist. Medi-Cal: providers: fraud.

Existing law provides for the Medi-Cal program, which is administered by the State Department of Health Care Services, under which qualified low-income individuals receive health care services. The Medi-Cal program is, in part, governed and funded by federal Medicaid Program provisions. Existing law requires an applicant or provider, as defined, to submit a complete application package for enrollment, continuing enrollment, or enrollment at a new location or a change in location, and requires that the application form for enrollment, the provider agreement, and all attachments or changes shall be signed under penalty of perjury. Existing law authorizes the department, upon receipt of reliable evidence, as described, of fraud or willful misrepresentation by a provider, to, among other things, withhold payment for any goods, services, supplies, or merchandise, or any portion thereof. Existing law prohibits the department from enrolling any applicant that has been convicted of any felony or misdemeanor involving fraud or abuse in any government program.

This bill would revise these provisions to require, upon receipt of a credible allegation of fraud against a provider, the provider to be

temporarily placed under payment suspension, unless it is determined there is good cause, as defined, not to suspend the payments or to suspend them only in part. This bill would prohibit the department from enrolling a provider in, or would require the department to terminate the provider from, the Medi-Cal program, if it is discovered that the provider has been terminated under Medicare or under the Medicaid Program or Children's Health Insurance Program in any state, and would provide that a temporary suspension may be lifted if a resolution of an investigation or fraud or abuse occurs, as defined. This bill would require, commencing as specified, the department to conduct a criminal background check and require submission of a set of fingerprints when the department designates a provider as a "high" categorical risk, as specified.

This bill would require the department, commencing as specified and with some exceptions, to collect an application fee for enrollment, revalidation of enrollment, or enrollment at a new location or a change in location in the amount calculated by the federal Centers for Medicare and Medicaid Services. This bill would authorize the department to establish a temporary moratorium on enrollment of providers under specified circumstances. This bill would make other related and conforming changes.

This bill would require, on a quarterly basis, the Department of Justice, and any other law enforcement agency that has accepted referrals for investigation from the department, to report to the department a listing of each referral, stating whether the referral continues to be under investigation and whether it involves a credible allegation of fraud. To the extent that this bill increases the duties of local law enforcement agencies, this bill would create a state-mandated local program.

The California Constitution requires the state to reimburse local agencies and school districts for certain costs mandated by the state. Statutory provisions establish procedures for making that reimbursement.

This bill would provide that, if the Commission on State Mandates determines that the bill contains costs mandated by the state, reimbursement for those costs shall be made pursuant to these statutory provisions.

Vote: majority. Appropriation: no. Fiscal committee: yes.  
State-mandated local program: yes.

*The people of the State of California do enact as follows:*

1     SECTION 1. Section 100185.5 of the Health and Safety Code  
2 is amended to read:

3     100185.5. (a) When a letter or order of denial of continued  
4 enrollment or suspension of any type or duration, based upon fraud  
5 or abuse, or a ~~withholding~~ *suspension* of payments, based upon  
6 ~~reliable evidence of fraud or willful misrepresentation~~, *a credible*  
7 *allegation of fraud* is issued by the department to a provider, the  
8 director shall review the evidence supporting the denial of  
9 continued enrollment, *suspension of providing services*, or  
10 ~~withholding~~ *suspension* of payments. If, in the opinion of the  
11 director, the evidence shows a ~~pattern or practice of fraud, abuse,~~  
12 ~~or willful misrepresentation~~ *credible allegation of fraud* that, if  
13 replicated in any other health care program administered by the  
14 department, could cause either fiscal loss to the state or harm to  
15 any participant, the director may deny continued enrollment, *or*  
16 suspend, or ~~withhold~~ *suspend* payments to, the provider with  
17 respect to those other health care programs. Any denial of  
18 continued enrollment, *suspension of providing services*, or  
19 ~~withholding~~ *suspension* of payments may be for an indefinite or  
20 definite period of time, may be stayed for a period of time, and  
21 may be with or without conditions or probation.

22     (b) The director may deny the application of an applicant or  
23 provider to participate in any health care program administered  
24 by the department, when, based upon fraud or abuse, the applicant  
25 or provider has been denied continued enrollment in, or suspended  
26 from, any health care program administered by the department, or  
27 has had payments ~~withheld~~ *suspended* based upon ~~reliable evidence~~  
28 ~~a credible allegation of fraud or willful misrepresentation in~~  
29 ~~connection with any health care program administered by the~~  
30 ~~department~~, and remains ineligible to participate in the health care  
31 program from which the applicant or provider was denied  
32 continued enrollment, suspended, or had payments ~~withheld~~  
33 *suspended*.

34     (c) The director may deny any new or additional application of  
35 a provider to participate in any health care program administered  
36 by the department if utilization controls including, but not limited  
37 to, prior authorization or special claims review pursuant to Sections  
38 51159, 51455, and 51460 of Title 22 of the California Code of

1 Regulations have been imposed upon that provider by any health  
2 care program administered by the department. Applications shall  
3 not be denied based solely upon utilization controls imposed upon  
4 an entire class or category of providers to which that provider  
5 belongs.

6 (d) Notwithstanding any other ~~provision of law~~, any provider  
7 or applicant ~~who~~ *that* has been denied continued enrollment in, or  
8 suspended from, or who has had payments ~~withheld~~ *suspended* in  
9 connection with, any health care program administered by the  
10 department, or whose application to participate in a health care  
11 program administered by the department is denied, pursuant to  
12 this section, may appeal that action in accordance with Section  
13 14043.65 of the Welfare and Institutions Code.

14 (e) For purposes of this section, the following definitions apply:

15 (1) “Abuse” has the same meaning as that term is defined in  
16 Section 14043.1 of the Welfare and Institutions Code.

17 (2) “Administered by the department” means administered by  
18 the State Department of Health *Care* Services or by its agents or  
19 contractors on behalf of the State Department of Health *Care*  
20 Services.

21 (3) ~~“Applicant” means any person, individual, partnership,~~  
22 ~~group, association, corporation, institution, or entity, and the~~  
23 ~~officers, directors, owners, managing employees, or agents thereof,~~  
24 ~~that applies to the department for enrollment as a provider or~~  
25 ~~participation as a provider in a health care program administered~~  
26 ~~by the department~~ *has the same meaning as that term is defined*  
27 *in Section 14043.1 of the Welfare and Institutions Code.*

28 (4) “Fraud” has the same meaning as that term is defined in  
29 Section 14043.1 of the Welfare and Institutions Code.

30 (5) ~~“Provider” means any person, individual, partnership, group,~~  
31 ~~association, corporation, institution, or entity, and the officers,~~  
32 ~~directors, owners, managing employees, or agents thereof, that~~  
33 ~~provides services, goods, supplies, or merchandise, directly or~~  
34 ~~indirectly, to a person enrolled in a health care program~~  
35 ~~administered by the department~~ *has the same meaning as that term*  
36 *is defined in Section 14043.1 of the Welfare and Institutions Code.*

37 (6) ~~“Withholding of payments”~~ *“Payment suspension”* means  
38 ~~the withholding~~ *suspension* of payments in accordance with Section  
39 14107.11 of the Welfare and Institutions Code.

(f) For purposes of this section, “suspension” includes, but is not limited to, suspensions authorized under Article 1.3 (commencing with Section 14043) or Article 3 (commencing with Section 14123) of Chapter 7 of Part 3 of Division 9 of the Welfare and Institutions Code.

(g) For purposes of this section, “health care program administered by the department” includes, but is not limited to, the Medi-Cal program.

SEC. 2. Section 14043.1 of the Welfare and Institutions Code is amended to read:

14043.1. As used in this article:

(a) “Abuse” means either of the following:

(1) Practices that are inconsistent with sound fiscal or business practices and result in unnecessary cost to the federal Medicaid and Medicare programs, the Medi-Cal program, another state’s Medicaid program, or other health care programs operated, or financed in whole or in part, by the federal government or a state or local agency in this state or another state.

(2) Practices that are inconsistent with sound medical practices and result in reimbursement by the federal Medicaid and Medicare programs, the Medi-Cal program or other health care programs operated, or financed in whole or in part, by the federal government or a state or local agency in this state or another state, for services that are unnecessary or for substandard items or services that fail to meet professionally recognized standards for health care.

(b) “Applicant” means an individual, partnership, group, association, corporation, institution, or entity, and the officers, directors, owners, managing employees, or agents thereof, that apply to the department for enrollment as a provider in the Medi-Cal program.

(c) “Application or application package” means a completed and signed application form, signed under penalty of perjury or notarized pursuant to Section 14043.25, a disclosure statement, a provider agreement, and all attachments or changes in the form, statement, or agreement.

(d) “Appropriate volume of business” means a volume that is consistent with the information provided in the application and any supplemental information provided by the applicant or provider, and is of a quality and type that would reasonably be

1 expected based upon the size and type of business operated by the  
2 applicant or provider.

3 (e) “Business address” means the location where an applicant  
4 or provider provides services, goods, supplies, or merchandise,  
5 directly or indirectly, to a Medi-Cal beneficiary. A post office box  
6 or commercial box is not a business address. The business address  
7 for the location of a vehicle or vessel owned and operated by an  
8 applicant or provider enrolled in the Medi-Cal program and used  
9 to provide services, goods, supplies, or merchandise, directly or  
10 indirectly, to a Medi-Cal beneficiary shall either be the business  
11 address location listed on the provider’s application as the location  
12 where similar services, goods, supplies, or merchandise would be  
13 provided or the applicant’s or provider’s pay to address.

14 (f) “Convicted” means any of the following:

15 (1) A judgment of conviction has been entered against an  
16 individual or entity by a federal, state, or local court, regardless  
17 of whether there is a posttrial motion, an appeal pending, or the  
18 judgment of conviction or other record relating to the criminal  
19 conduct has been expunged or otherwise removed.

20 (2) A federal, state, or local court has made a finding of guilt  
21 against an individual or entity.

22 (3) A federal, state, or local court has accepted a plea of guilty  
23 or nolo contendere by an individual or entity.

24 (4) An individual or entity has entered into participation in a  
25 first offender, deferred adjudication, or other program or  
26 arrangement where judgment of conviction has been withheld.

27 (g) “Debt due and owing” means 60 days have passed since a  
28 notice or demand for repayment of an overpayment or another  
29 amount resulting from an audit or examination, for a penalty  
30 assessment, or for another amount due to the department was sent  
31 to the provider, regardless of whether the provider is an institutional  
32 provider or a noninstitutional provider and regardless of whether  
33 an appeal is pending.

34 (h) “Enrolled or enrollment in the Medi-Cal program” means  
35 authorized under any processes by the department or its agents or  
36 contractors to receive, directly or indirectly, reimbursement for  
37 the provision of services, goods, supplies, or merchandise to a  
38 Medi-Cal beneficiary.

39 (i) “Fraud” means an intentional deception or misrepresentation  
40 made by a person with the knowledge that the deception could

1 result in some unauthorized benefit to himself or herself or some  
2 other person. It includes any act that constitutes fraud under  
3 applicable federal or state law.

4 (j) “Location” means a street, city, or rural route address or a  
5 site or place within a street, city, or rural route address, and the  
6 city, county, state, and nine-digit ZIP Code.

7 (k) “Not currently enrolled at the location for which the  
8 application is submitted” means either of the following:

9 (1) The provider is changing location and moving to a different  
10 location than that for which the provider was issued a provider  
11 number.

12 (2) The provider is adding a business address.

13 (l) (1) “Individual dentist practice” means a dentist licensed by  
14 the Dental Board of California enrolled or enrolling in Medi-Cal  
15 as an individual provider who is a sole proprietor of his or her  
16 practice or is a corporation owned solely by the individual dentist  
17 and the only dentist practitioner is the owner. An individual dentist  
18 practice may include nondentist allied dental health professionals  
19 employed and supervised by the dentist.

20 (2) “Individual physician practice” means a physician and  
21 surgeon licensed by the Medical Board of California or the  
22 Osteopathic Medical Board of California enrolled or enrolling in  
23 Medi-Cal as an individual provider who is sole proprietor of his  
24 or her practice or is a corporation owned solely by the individual  
25 physician and the only physician practitioner is the owner. An  
26 individual physician practice may include nonphysician medical  
27 practitioners employed and supervised by the physician.

28 (m) “Preenrollment period” or “preenrollment” includes the  
29 period of time during which an application package for enrollment,  
30 continued enrollment, or for the addition of or change in a location  
31 is pending.

32 (n) “Professionally recognized standards of health care” means  
33 statewide or national standards of care, whether in writing or not,  
34 that professional peers of the individual or entity whose provision  
35 of care is an issue recognize as applying to those peers practicing  
36 or providing care within a state. When the United States  
37 Department of Health and Human Services has declared a treatment  
38 modality not to be safe and effective, practitioners that employ  
39 that treatment modality shall be deemed not to meet professionally  
40 recognized standards of health care. This subdivision shall not be

1 construed to mean that all other treatments meet professionally  
2 recognized standards of care.

3 (o) “Provider” means an individual, partnership, group,  
4 association, corporation, institution, or entity, and the officers,  
5 directors, owners, managing employees, or agents of a partnership,  
6 group association, corporation, institution, or entity, that provides  
7 services, goods, supplies, or merchandise, directly or indirectly,  
8 to a Medi-Cal beneficiary and that has been enrolled in the  
9 Medi-Cal program.

10 (p) “*Resolution of an investigation for fraud or abuse*” means  
11 *there is no documentation to indicate either that a charge or*  
12 *accusation has been filed against the provider and either (1) the*  
13 *investigation has not been active at any time during the previous*  
14 *12 months or (2) the department has been unable, for a period of*  
15 *12 months, to contact an investigator or responsible representative*  
16 *of any agency investigating the provider.*

17 ~~(p)~~

18 (q) “Unnecessary or substandard items or services” means those  
19 that are either of the following:

20 (1) Substantially in excess of the provider’s usual charges or  
21 costs for the items or services.

22 (2) Furnished, or caused to be furnished, to patients, whether  
23 or not covered by Medicare, Medicaid, or any of the state health  
24 care programs to which the definitions of applicant and provider  
25 apply, and which are substantially in excess of the patient’s needs,  
26 or of a quality that fails to meet professionally recognized standards  
27 of health care. The department’s determination that the items or  
28 services furnished were excessive or of unacceptable quality shall  
29 be made on the basis of information, including sanction reports,  
30 from the following sources:

31 (A) The professional review organization for the area served  
32 by the individual or entity.

33 (B) State or local licensing or certification authorities.

34 (C) Fiscal agents or contractors or private insurance companies.

35 (D) State or local professional societies.

36 (E) Any other sources deemed appropriate by the department.

37 (r) *This section shall become inoperative on the effective date*  
38 *of the necessary state plan amendment, as stated in the declaration*  
39 *executed by the director pursuant to Section 14043.1 as added by*



1 *Section 3 of the act that added this subdivision, and is repealed*  
2 *on the January 1 of the following year.*

3 SEC. 3. Section 14043.1 is added to the Welfare and  
4 Institutions Code, to read:

5 14043.1. As used in this article:

6 (a) “Abuse” means either of the following:

7 (1) Practices that are inconsistent with sound fiscal or business  
8 practices and result in unnecessary cost to the federal Medicaid  
9 and Medicare programs, the Medi-Cal program, another state’s  
10 Medicaid program, or other health care programs operated, or  
11 financed in whole or in part, by the federal government or a state  
12 or local agency in this state or another state.

13 (2) Practices that are inconsistent with sound medical practices  
14 and result in reimbursement by the federal Medicaid and Medicare  
15 programs, the Medi-Cal program or other health care programs  
16 operated, or financed in whole or in part, by the federal government  
17 or a state or local agency in this state or another state, for services  
18 that are unnecessary or for substandard items or services that fail  
19 to meet professionally recognized standards for health care.

20 (b) “Applicant” means an individual, including an ordering,  
21 referring, or prescribing individual, partnership, group, association,  
22 corporation, institution, or entity, and the officers, directors,  
23 owners, managing employees, or agents thereof, that apply to the  
24 department for enrollment as a provider in the Medi-Cal program.

25 (c) “Application or application package” means a completed  
26 and signed application form, signed under penalty of perjury or  
27 notarized pursuant to Section 14043.25, a disclosure statement, a  
28 provider agreement, and all attachments or changes in the form,  
29 statement, or agreement.

30 (d) “Appropriate volume of business” means a volume that is  
31 consistent with the information provided in the application and  
32 any supplemental information provided by the applicant or  
33 provider, and is of a quality and type that would reasonably be  
34 expected based upon the size and type of business operated by the  
35 applicant or provider.

36 (e) “Business address” means the location where an applicant  
37 or provider provides services, goods, supplies, or merchandise,  
38 directly or indirectly, to a Medi-Cal beneficiary. A post office box  
39 or commercial box is not a business address. The business address  
40 for the location of a vehicle or vessel owned and operated by an

1 applicant or provider enrolled in the Medi-Cal program and used  
2 to provide services, goods, supplies, or merchandise, directly or  
3 indirectly, to a Medi-Cal beneficiary shall either be the business  
4 address location listed on the provider's application as the location  
5 where similar services, goods, supplies, or merchandise would be  
6 provided or the applicant's or provider's pay to address.

7 (f) "Convicted" means any of the following:

8 (1) A judgment of conviction has been entered against an  
9 individual or entity by a federal, state, or local court, regardless  
10 of whether there is a posttrial motion, an appeal pending, or the  
11 judgment of conviction or other record relating to the criminal  
12 conduct has been expunged or otherwise removed.

13 (2) A federal, state, or local court has made a finding of guilt  
14 against an individual or entity.

15 (3) A federal, state, or local court has accepted a plea of guilty  
16 or nolo contendere by an individual or entity.

17 (4) An individual or entity has entered into participation in a  
18 first offender, deferred adjudication, or other program or  
19 arrangement where judgment of conviction has been withheld.

20 (g) "Debt due and owing" means 60 days have passed since a  
21 notice or demand for repayment of an overpayment or another  
22 amount resulting from an audit or examination, for a penalty  
23 assessment, or for another amount due to the department was sent  
24 to the provider, regardless of whether the provider is an institutional  
25 provider or a noninstitutional provider and regardless of whether  
26 an appeal is pending.

27 (h) "Enrolled or enrollment in the Medi-Cal program" means  
28 authorized under any processes by the department or its agents or  
29 contractors to receive, directly or indirectly, reimbursement for  
30 the provision of services, goods, supplies, or merchandise to a  
31 Medi-Cal beneficiary.

32 (i) "Fraud" means an intentional deception or misrepresentation  
33 made by a person with the knowledge that the deception could  
34 result in some unauthorized benefit to himself or herself or some  
35 other person. It includes any act that constitutes fraud under  
36 applicable federal or state law.

37 (j) "Location" means a street, city, or rural route address or a  
38 site or place within a street, city, or rural route address, and the  
39 city, county, state, and nine-digit ZIP Code.

1 (k) “Not currently enrolled at the location for which the  
2 application is submitted” means either of the following:

3 (1) The provider is changing location and moving to a different  
4 location than that for which the provider was issued a provider  
5 number.

6 (2) The provider is adding a business address.

7 (l) (1) “Individual dentist practice” means a dentist licensed by  
8 the Dental Board of California enrolled or enrolling in Medi-Cal  
9 as an individual provider who is a sole proprietor of his or her  
10 practice or is a corporation owned solely by the individual dentist  
11 and the only dentist practitioner is the owner. An individual dentist  
12 practice may include nondentist allied dental health professionals  
13 employed and supervised by the dentist.

14 (2) “Individual physician practice” means a physician and  
15 surgeon licensed by the Medical Board of California or the  
16 Osteopathic Medical Board of California enrolled or enrolling in  
17 Medi-Cal as an individual provider who is sole proprietor of his  
18 or her practice or is a corporation owned solely by the individual  
19 physician and the only physician practitioner is the owner. An  
20 individual physician practice may include nonphysician medical  
21 practitioners employed and supervised by the physician.

22 (m) “Preenrollment period” or “preenrollment” includes the  
23 period of time during which an application package for enrollment,  
24 continued enrollment, or for the addition of or change in a location  
25 is pending.

26 (n) “Professionally recognized standards of health care” means  
27 statewide or national standards of care, whether in writing or not,  
28 that professional peers of the individual or entity whose provision  
29 of care is an issue recognize as applying to those peers practicing  
30 or providing care within a state. When the United States  
31 Department of Health and Human Services has declared a treatment  
32 modality not to be safe and effective, practitioners that employ  
33 that treatment modality shall be deemed not to meet professionally  
34 recognized standards of health care. This subdivision shall not be  
35 construed to mean that all other treatments meet professionally  
36 recognized standards of care.

37 (o) “Provider” means an individual, partnership, group,  
38 association, corporation, institution, or entity, and the officers,  
39 directors, owners, managing employees, or agents of a partnership,  
40 group association, corporation, institution, or entity, that provides

1 services, goods, supplies, or merchandise, directly or indirectly,  
2 including all ordering, referring, and prescribing, to a Medi-Cal  
3 beneficiary and that has been enrolled in the Medi-Cal program.

4 (p) “Resolution of an investigation for fraud or abuse” means  
5 there is no documentation to indicate either that a charge or  
6 accusation has been filed against the provider and either (1) the  
7 investigation has not been active at any time during the previous  
8 12 months or (2) the department has been unable, for a period of  
9 12 months, to contact an investigator or responsible representative  
10 of any agency investigating the provider.

11 (q) “Unnecessary or substandard items or services” means those  
12 that are either of the following:

13 (1) Substantially in excess of the provider’s usual charges or  
14 costs for the items or services.

15 (2) Furnished, or caused to be furnished, to patients, whether  
16 or not covered by Medicare, Medicaid, or any of the state health  
17 care programs to which the definitions of applicant and provider  
18 apply, and which are substantially in excess of the patient’s needs,  
19 or of a quality that fails to meet professionally recognized standards  
20 of health care. The department’s determination that the items or  
21 services furnished were excessive or of unacceptable quality shall  
22 be made on the basis of information, including sanction reports,  
23 from the following sources:

24 (A) The professional review organization for the area served  
25 by the individual or entity.

26 (B) State or local licensing or certification authorities.

27 (C) Fiscal agents or contractors or private insurance companies.

28 (D) State or local professional societies.

29 (E) Any other sources deemed appropriate by the department.

30 (r) (1) This section shall become operative on the effective date  
31 of the state plan amendment necessary to implement this section,  
32 as stated in the declaration executed by the director pursuant to  
33 paragraph (2).

34 (2) Upon approval of the state plan amendment necessary to  
35 implement this section under Sections 455.410 and 455.440 of  
36 Title 42 of the Code of Federal Regulations, the director shall  
37 execute a declaration, to be retained by the director, that states that  
38 this approval has been obtained and the effective date of the state  
39 plan amendment.

1 SEC. 4. Section 14043.15 of the Welfare and Institutions Code  
2 is amended to read:

3 14043.15. (a) The department may adopt regulations for  
4 certification of each applicant and each provider in the Medi-Cal  
5 program. No certification shall be required for natural persons  
6 licensed or certificated under Division 2 (commencing with Section  
7 500) of the Business and Professions Code, the Osteopathic  
8 Initiative Act or the Chiropractic Initiative Act.

9 (b) (1) An applicant or provider who is a natural person, and  
10 is licensed or certificated pursuant to Division 2 (commencing  
11 with Section 500) of the Business and Professions Code, the  
12 Osteopathic Initiative Act, or the Chiropractic Initiative Act, or is  
13 a professional corporation, as defined in subdivision (b) of Section  
14 13401 of the Corporations Code, shall comply with Section  
15 14043.26 and shall be enrolled in the Medi-Cal program as either  
16 an individual provider or as a rendering provider in a provider  
17 group for each application package submitted and approved  
18 pursuant to Section 14043.26, notwithstanding that the applicant  
19 or provider meets the requirements to qualify as exempt from clinic  
20 licensure under subdivision (a) or (m) of Section 1206 of the Health  
21 and Safety Code.

22 (2) A provider enrolled in the Medi-Cal program pursuant to  
23 paragraph (1), who has disclosed in the application package for  
24 enrollment that the provider's practice includes the rendering of  
25 services, goods, supplies, or merchandise solely at one, or at more  
26 than one, health facility, as defined in Section 1250 of the Health  
27 and Safety Code, or clinic, as defined in Section 1204 of the Health  
28 and Safety Code, or medical therapy unit, for purposes of Section  
29 123950 of the Health and Safety Code, or residence of the  
30 provider's patient, or office of a physician and surgeon involved  
31 in the care and treatment of the provider's patients, shall not be  
32 required to enroll at each such health facility, clinic, medical  
33 therapy unit, patient's residence or physician and surgeon's office  
34 location and may utilize the business addresses listed on the  
35 application for enrollment pursuant to paragraph (1) to claim  
36 reimbursement from the Medi-Cal program for services rendered  
37 by the provider to Medi-Cal beneficiaries at all of those health  
38 facilities, clinics, medical therapy units, residences, or physician  
39 offices.

(3) This subdivision shall not be interpreted to allow the violation of any state or federal law governing fiscal intermediaries or Division 2 (commencing with Section 500) of the Business and Professions Code, the Osteopathic Initiative Act, or the Chiropractic Initiative Act. This subdivision does not remove the requirement that each claim for reimbursement from the Medi-Cal program identify the place of service and the rendering provider.

(c) An applicant or provider licensed as a clinic pursuant to Chapter 1 (commencing with Section 1200) of, or a health facility licensed pursuant to Chapter 2 (commencing with Section 1250) of, Division 2 of the Health and Safety Code may be enrolled in the Medi-Cal program as a clinic or a health facility and need not comply with Section 14043.26 if the clinic or health facility is certified by the department to participate in the Medi-Cal program.

(d) An applicant or provider that meets the requirements to qualify as exempt from clinic licensure under subdivisions (b) to (l), inclusive, or subdivisions (n) to (p), inclusive, of Section 1206 of the Health and Safety Code shall comply with Section 14043.26 and may be enrolled in the Medi-Cal program as either a clinic or within any other provider category for which the applicant or provider qualifies. An applicant or provider to which any of the clinic licensure exemptions specified in this subdivision apply shall identify the licensure exemption category and document in its application package the legal and factual basis for the clinic license exemption claimed.

(e) Notwithstanding subdivisions (a), (b), (c), and (d), an applicant or provider that meets the requirements to qualify as exempt from clinic licensure pursuant to subdivision (h) of Section 1206 of the Health and Safety Code, including an intermittent site that is operated by a licensed primary care clinic or an affiliated mobile health care unit licensed or approved under Chapter 9 (commencing with Section 1765.101) of Division 2 of the Health and Safety Code, and that is operated by a licensed primary care clinic, and for which intermittent site or mobile health unit the licensed primary care clinic directly or indirectly provides all staffing, protocols, equipment, supplies, and billing services, need not enroll in the Medi-Cal program as a separate provider and need not comply with Section 14043.26 if the licensed primary care clinic operating the applicant, provider clinic, or mobile health

1 care unit has notified the department of its separate locations,  
2 premises, intermittent sites, or mobile health care units.

3 *(f) This section shall become inoperative on the effective date*  
4 *of the necessary state plan amendment, as stated in the declaration*  
5 *executed by the director pursuant to Section 14043.15 as added*  
6 *by Section 5 of the act that added this subdivision, and is repealed*  
7 *on the January 1 of the following year.*

8 SEC. 5. Section 14043.15 is added to the Welfare and  
9 Institutions Code, to read:

10 14043.15. (a) The department may adopt regulations for  
11 certification of each applicant and each provider in the Medi-Cal  
12 program. No certification shall be required for natural persons  
13 licensed or certificated under Division 2 (commencing with Section  
14 500) of the Business and Professions Code, the Osteopathic  
15 Initiative Act, or the Chiropractic Initiative Act.

16 (b) (1) An applicant or provider who is a natural person, and  
17 is licensed or certificated pursuant to Division 2 (commencing  
18 with Section 500) of the Business and Professions Code, the  
19 Osteopathic Initiative Act, or the Chiropractic Initiative Act, or is  
20 a professional corporation, as defined in subdivision (b) of Section  
21 13401 of the Corporations Code, shall comply with Section  
22 14043.26 and shall be enrolled in the Medi-Cal program as either  
23 an individual provider or as a rendering provider in a provider  
24 group for each application package submitted and approved  
25 pursuant to Section 14043.26, notwithstanding that the applicant  
26 or provider meets the requirements to qualify as exempt from clinic  
27 licensure under subdivision (a) or (m) of Section 1206 of the Health  
28 and Safety Code.

29 (2) A provider enrolled in the Medi-Cal program pursuant to  
30 paragraph (1), who has disclosed in the application package for  
31 enrollment that the provider's practice includes the rendering of  
32 services, goods, supplies, or merchandise solely at one, or at more  
33 than one, health facility, as defined in Section 1250 of the Health  
34 and Safety Code, or clinic, as defined in Section 1204 of the Health  
35 and Safety Code, or medical therapy unit, for purposes of Section  
36 123950 of the Health and Safety Code, or residence of the  
37 provider's patient, or office of a physician and surgeon involved  
38 in the care and treatment of the provider's patients, shall not be  
39 required to enroll at each such health facility, clinic, medical  
40 therapy unit, patient's residence or physician and surgeon's office

1 location and may utilize the business addresses listed on the  
2 application for enrollment pursuant to paragraph (1) to claim  
3 reimbursement from the Medi-Cal program for services rendered  
4 by the provider to Medi-Cal beneficiaries at all of those health  
5 facilities, clinics, medical therapy units, residences, or physician  
6 offices.

7 (3) This subdivision shall not be interpreted to allow the  
8 violation of any state or federal law governing fiscal intermediaries  
9 or Division 2 (commencing with Section 500) of the Business and  
10 Professions Code, the Osteopathic Initiative Act, or the  
11 Chiropractic Initiative Act. This subdivision does not remove the  
12 requirement that each claim for reimbursement from the Medi-Cal  
13 program identify the place of service and the rendering, ordering,  
14 or prescribing provider.

15 (c) An applicant or provider licensed as a clinic pursuant to  
16 Chapter 1 (commencing with Section 1200) of, or a health facility  
17 licensed pursuant to Chapter 2 (commencing with Section 1250)  
18 of, Division 2 of the Health and Safety Code may be enrolled in  
19 the Medi-Cal program as a clinic or a health facility and need not  
20 comply with Section 14043.26 if the clinic or health facility is  
21 certified by the department to participate in the Medi-Cal program.

22 (d) An applicant or provider that meets the requirements to  
23 qualify as exempt from clinic licensure under subdivisions (b) to  
24 (l), inclusive, or subdivisions (n) to (p), inclusive, of Section 1206  
25 of the Health and Safety Code shall comply with Section 14043.26  
26 and may be enrolled in the Medi-Cal program as either a clinic or  
27 within any other provider category for which the applicant or  
28 provider qualifies. An applicant or provider to which any of the  
29 clinic licensure exemptions specified in this subdivision apply  
30 shall identify the licensure exemption category and document in  
31 its application package the legal and factual basis for the clinic  
32 license exemption claimed.

33 (e) Notwithstanding subdivisions (a), (b), (c), and (d), an  
34 applicant or provider that meets the requirements to qualify as  
35 exempt from clinic licensure pursuant to subdivision (h) of Section  
36 1206 of the Health and Safety Code, including an intermittent site  
37 that is operated by a licensed primary care clinic or an affiliated  
38 mobile health care unit licensed or approved under Chapter 9  
39 (commencing with Section 1765.101) of Division 2 of the Health  
40 and Safety Code, and that is operated by a licensed primary care



1 clinic, and for which intermittent site or mobile health unit the  
2 licensed primary care clinic directly or indirectly provides all  
3 staffing, protocols, equipment, supplies, and billing services, need  
4 not enroll in the Medi-Cal program as a separate provider and need  
5 not comply with Section 14043.26 if the licensed primary care  
6 clinic operating the applicant, provider clinic, or mobile health  
7 care unit has notified the department of its separate locations,  
8 premises, intermittent sites, or mobile health care units.

9 (f) (1) This section shall become operative on the effective date  
10 of the state plan amendment necessary to implement this section,  
11 as stated in the declaration executed by the director pursuant to  
12 paragraph (2).

13 (2) Upon approval of the state plan amendment necessary to  
14 implement this section under Sections 455.410 and 455.440 of  
15 Title 42 of the Code of Federal Regulations, the director shall  
16 execute a declaration, to be retained by the director, that states that  
17 this approval has been obtained and the effective date of the state  
18 plan amendment.

19 SEC. 6. Section 14043.2 of the Welfare and Institutions Code  
20 is amended to read:

21 14043.2. (a) Whether or not regulations for certification are  
22 adopted under Section 14043.15, in order to be enrolled as a  
23 provider, or for enrollment as a provider to continue, an applicant  
24 or provider may be required to sign a provider agreement and shall  
25 disclose all information as required in federal ~~medicaid~~ *Medicaid*  
26 regulations and any other information required by the department.  
27 Applicants, providers, and persons with an ownership or control  
28 interest, as defined in federal ~~medicaid~~ *Medicaid* regulations, shall  
29 submit their *date of birth and their* social security number or  
30 numbers to the department, to the full extent allowed under federal  
31 law. *Corporations with an ownership or control interest, as defined*  
32 *in federal Medicaid regulations, shall submit their taxpayer*  
33 *identification number and all business address locations and post*  
34 *office box addresses.* The director may designate the form of a  
35 provider agreement by provider type. Failure to disclose the  
36 required information, or the disclosure of false information, shall  
37 result in denial of the application for enrollment or shall make the  
38 provider subject to temporary suspension from the Medi-Cal  
39 program, which shall include ~~temporary~~ deactivation of the  
40 provider's number or numbers, including all business addresses

1 used by the provider to obtain reimbursement from the Medi-Cal  
2 program.

3 (b) The director shall notify the provider of the temporary  
4 suspension and deactivation of the provider's number or numbers,  
5 including all business addresses used by the provider, and the  
6 effective date thereof. Notwithstanding Section 100171 of the  
7 Health and Safety Code and Section 14123, proceedings after the  
8 imposition of sanctions provided for in subdivision (a) shall be in  
9 accordance with Section 14043.65.

10 SEC. 7. Section 14043.25 of the Welfare and Institutions Code  
11 is amended to read:

12 14043.25. (a) The application form for enrollment, the provider  
13 agreement, and all attachments or changes to either, shall be signed  
14 under penalty of perjury.

15 (b) The department may require that the application form for  
16 enrollment, the provider agreement, and all attachments or changes  
17 to either, submitted by an applicant or provider licensed pursuant  
18 to Division 2 (commencing with Section 500) of the Business and  
19 Professions Code, the Osteopathic Initiative Act, or the  
20 Chiropractic Initiative Act, be notarized.

21 (c) Application forms for enrollment, provider agreements, and  
22 all attachments or changes to either, submitted by an applicant or  
23 provider not subject to subdivision (b) shall be notarized. This  
24 subdivision shall not apply with respect to providers under the  
25 In-Home Supportive Services program.

26 (d) *This section shall become inoperative on the effective date*  
27 *of the state plan amendment, as stated in the declaration executed*  
28 *by the director pursuant to Section 14043.25 as added by Section*  
29 *8 of the act that added this subdivision, and is repealed on the*  
30 *January 1 of the following year.*

31 SEC. 8. Section 14043.25 is added to the Welfare and  
32 Institutions Code, to read:

33 14043.25. (a) The application form for enrollment, the provider  
34 agreement, and all attachments or changes to either, shall be signed  
35 under penalty of perjury.

36 (b) The department may require that the application form for  
37 enrollment, the provider agreement, and all attachments or changes  
38 to either, submitted by an applicant or provider licensed pursuant  
39 to Division 2 (commencing with Section 500) of the Business and

1 Professions Code, the Osteopathic Initiative Act, or the  
2 Chiropractic Initiative Act, be notarized.

3 (c) Application forms for enrollment, provider agreements, and  
4 all attachments or changes to either, submitted by an applicant or  
5 provider not subject to subdivision (b) shall be notarized. This  
6 subdivision shall not apply with respect to providers under the  
7 In-Home Supportive Services program.

8 (d) The department shall collect an application fee for  
9 enrollment, revalidation of enrollment, or enrollment at a new  
10 location or a change in location. The application fee shall not be  
11 collected from individual physicians or nonphysician practitioners,  
12 from providers that are enrolled in Medicare another state's  
13 Medicaid or Children's Health Insurance program, from providers  
14 that submit proof that they have paid the applicable fee to a  
15 Medicare contractor or to another state's Medicaid program, or  
16 pursuant to an exemption or waiver pursuant to federal law. The  
17 application fee collected shall be in the amount calculated by the  
18 federal Centers for Medicare and Medicaid Services in effect for  
19 the calendar year during which the application for enrollment is  
20 received by the department.

21 (e) (1) This section shall become operative on the effective date  
22 of the state plan amendment necessary to implement this section,  
23 as stated in the declaration executed by the director pursuant to  
24 paragraph (2).

25 (2) Upon approval of the state plan amendment necessary to  
26 implement this section, the director shall execute a declaration, to  
27 be retained by the director, that states this approval has been  
28 obtained and the effective date of the state plan amendment.

29 SEC. 9. Section 14043.26 of the Welfare and Institutions Code  
30 is amended to read:

31 14043.26. (a) (1) On and after January 1, 2004, an applicant  
32 that currently is not enrolled in the Medi-Cal program, or a provider  
33 applying for continued enrollment, upon written notification from  
34 the department that enrollment for continued participation of all  
35 providers in a specific provider of service category or subgroup  
36 of that category to which the provider belongs will occur, or, except  
37 as provided in subdivisions (b) and (e), a provider not currently  
38 enrolled at a location where the provider intends to provide  
39 services, goods, supplies, or merchandise to a Medi-Cal  
40 beneficiary, shall submit a complete application package for

1 enrollment, continuing enrollment, or enrollment at a new location  
2 or a change in location.

3 (2) Clinics licensed by the department pursuant to Chapter 1  
4 (commencing with Section 1200) of Division 2 of the Health and  
5 Safety Code and certified by the department to participate in the  
6 Medi-Cal program shall not be subject to this section.

7 (3) Health facilities licensed by the department pursuant to  
8 Chapter 2 (commencing with Section 1250) of Division 2 of the  
9 Health and Safety Code and certified by the department to  
10 participate in the Medi-Cal program shall not be subject to this  
11 section.

12 (4) Adult day health care providers licensed pursuant to Chapter  
13 3.3 (commencing with Section 1570) of Division 2 of the Health  
14 and Safety Code and certified by the department to participate in  
15 the Medi-Cal program shall not be subject to this section.

16 (5) Home health agencies licensed pursuant to Chapter 8  
17 (commencing with Section 1725) of Division 2 of the Health and  
18 Safety Code and certified by the department to participate in the  
19 Medi-Cal program shall not be subject to this section.

20 (6) Hospices licensed pursuant to Chapter 8.5 (commencing  
21 with Section 1745) of Division 2 of the Health and Safety Code  
22 and certified by the department to participate in the Medi-Cal  
23 program shall not be subject to this section.

24 (b) A physician and surgeon licensed by the Medical Board of  
25 California or the Osteopathic Medical Board of California, or a  
26 dentist licensed by the Dental Board of California, practicing as  
27 an individual physician practice or as an individual dentist practice,  
28 as defined in Section 14043.1, who is enrolled and in good standing  
29 in the Medi-Cal program, and who is changing locations of that  
30 individual physician practice or individual dentist practice within  
31 the same county, shall be eligible to continue enrollment at the  
32 new location by filing a change of location form to be developed  
33 by the department. The form shall comply with all minimum  
34 federal requirements related to Medicaid provider enrollment.  
35 Filing this form shall be in lieu of submitting a complete  
36 application package pursuant to subdivision (a).

37 (c) (1) Except as provided in paragraph (2), within 30 days  
38 after receiving an application package submitted pursuant to  
39 subdivision (a), the department shall provide written notice that  
40 the application package has been received and, if applicable, that

1 there is a moratorium on the enrollment of providers in the specific  
2 provider of service category or subgroup of the category to which  
3 the applicant or provider belongs. This moratorium shall bar further  
4 processing of the application package.

5 (2) Within 15 days after receiving an application package from  
6 a physician, or a group of physicians, licensed by the Medical  
7 Board of California or the Osteopathic Medical Board of California,  
8 or a change of location form pursuant to subdivision (b), the  
9 department shall provide written notice that the application package  
10 or the change of location form has been received.

11 (d) (1) If the application package submitted pursuant to  
12 subdivision (a) is from an applicant or provider who meets the  
13 criteria listed in paragraph (2), the applicant or provider shall be  
14 considered a preferred provider and shall be granted preferred  
15 provisional provider status pursuant to this section and for a period  
16 of no longer than 18 months, effective from the date on the notice  
17 from the department. The ability to request consideration as a  
18 preferred provider and the criteria necessary for the consideration  
19 shall be publicized to all applicants and providers. An applicant  
20 or provider who desires consideration as a preferred provider  
21 pursuant to this subdivision shall request consideration from the  
22 department by making a notation to that effect on the application  
23 package, by cover letter, or by other means identified by the  
24 department in a provider bulletin. Request for consideration as a  
25 preferred provider shall be made with each application package  
26 submitted in order for the department to grant the consideration.  
27 An applicant or provider who requests consideration as a preferred  
28 provider shall be notified within 60 days whether the applicant or  
29 provider meets or does not meet the criteria listed in paragraph  
30 (2). If an applicant or provider is notified that the applicant or  
31 provider does not meet the criteria for a preferred provider, the  
32 application package submitted shall be processed in accordance  
33 with the remainder of this section.

34 (2) To be considered a preferred provider, the applicant or  
35 provider shall meet all of the following criteria:

36 (A) Hold a current license as a physician and surgeon issued by  
37 the Medical Board of California or the Osteopathic Medical Board  
38 of California, which license shall not have been revoked, whether  
39 stayed or not, suspended, placed on probation, or subject to other  
40 limitation.

(B) Be a current faculty member of a teaching hospital or a children's hospital, as defined in Section 10727, accredited by the Joint Commission or the American Osteopathic Association, or be credentialed by a health care service plan that is licensed under the Knox-Keene Health Care Service Plan Act of 1975 (Chapter 2.2 (commencing with Section 1340) of Division 2 of the Health and Safety Code) or county organized health system, or be a current member in good standing of a group that is credentialed by a health care service plan that is licensed under the Knox-Keene Act.

(C) Have full, current, unrevoked, and unsuspended privileges at a Joint Commission or American Osteopathic Association accredited general acute care hospital.

(D) Not have any adverse entries in the federal Healthcare Integrity and Protection Data Bank.

(3) The department may recognize other providers as qualifying as preferred providers if criteria similar to those set forth in paragraph (2) are identified for the other providers. The department shall consult with interested parties and appropriate stakeholders to identify similar criteria for other providers so that they may be considered as preferred providers.

(e) (1) If a Medi-Cal applicant meets the criteria listed in paragraph (2), the applicant shall be enrolled in the Medi-Cal program after submission and review of a short form application to be developed by the department. The form shall comply with all minimum federal requirements related to Medicaid provider enrollment. The department shall notify the applicant that the department has received the application within 15 days of receipt of the application. The department shall ~~issue~~ *enroll* the applicant ~~a provider number~~ or notify the applicant that the applicant does not meet the criteria listed in paragraph (2) within 90 days of receipt of the application.

(2) Notwithstanding any other provision of law, an applicant or provider who meets all of the following criteria shall be eligible for enrollment in the Medi-Cal program pursuant to this subdivision, after submission and review of a short form application:

(A) The applicant's or provider's practice is based in one or more of the following: a general acute care hospital, a rural general acute care hospital, or an acute psychiatric hospital, as defined in

1 subdivisions (a) and (b) of Section 1250 of the Health and Safety  
2 Code.

3 (B) The applicant or provider holds a current, unrevoked, or  
4 unsuspended license as a physician and surgeon issued by the  
5 Medical Board of California or the Osteopathic Medical Board of  
6 California. An applicant or provider shall not be in compliance  
7 with this subparagraph if a license revocation has been stayed, the  
8 licensee has been placed on probation, or the license is subject to  
9 any other limitation.

10 (C) The applicant or provider does not have an adverse entry  
11 in the federal Healthcare Integrity and Protection Data Bank.

12 (3) An applicant shall be granted provisional provider status  
13 under this subdivision for a period of 12 months.

14 (f) Except as provided in subdivision (g), within 180 days after  
15 receiving an application package submitted pursuant to subdivision  
16 (a), or from the date of the notice to an applicant or provider that  
17 the applicant or provider does not qualify as a preferred provider  
18 under subdivision (d), the department shall give written notice to  
19 the applicant or provider that any of the following applies, or shall  
20 on the 181st day grant the applicant or provider provisional  
21 provider status pursuant to this section for a period no longer than  
22 12 months, effective from the 181st day:

23 (1) The applicant or provider is being granted provisional  
24 provider status for a period of 12 months, effective from the date  
25 on the notice.

26 (2) The application package is incomplete. The notice shall  
27 identify additional information or documentation that is needed to  
28 complete the application package.

29 (3) The department is exercising its authority under Section  
30 14043.37, 14043.4, or 14043.7, and is conducting background  
31 checks, preenrollment inspections, or unannounced visits.

32 (4) The application package is denied for any of the following  
33 reasons:

34 (A) Pursuant to Section 14043.2 or 14043.36.

35 (B) For lack of a license necessary to perform the health care  
36 services or to provide the goods, supplies, or merchandise directly  
37 or indirectly to a Medi-Cal beneficiary, within the applicable  
38 provider of service category or subgroup of that category.

39 (C) The period of time during which an applicant or provider  
40 has been barred from reapplying has not passed.

1 (D) For other stated reasons authorized by law.

2 (g) Notwithstanding subdivision (f), within 90 days after  
3 receiving an application package submitted pursuant to subdivision  
4 (a) from a physician or physician group licensed by the Medical  
5 Board of California or the Osteopathic Medical Board of California,  
6 or from the date of the notice to that physician or physician group  
7 that does not qualify as a preferred provider under subdivision (d),  
8 or within 90 days after receiving a change of location form  
9 submitted pursuant to subdivision (b), the department shall give  
10 written notice to the applicant or provider that either paragraph  
11 (1), (2), (3), or (4) of subdivision (f) applies, or shall on the 91st  
12 day grant the applicant or provider provisional provider status  
13 pursuant to this section for a period no longer than 12 months,  
14 effective from the 91st day.

15 (h) (1) If the application package that was noticed as incomplete  
16 under paragraph (2) of subdivision (f) is resubmitted with all  
17 requested information and documentation, and received by the  
18 department within 60 days of the date on the notice, the department  
19 shall, within 60 days of the resubmission, send a notice that any  
20 of the following applies:

21 (A) The applicant or provider is being granted provisional  
22 provider status for a period of 12 months, effective from the date  
23 on the notice.

24 (B) The application package is denied for any other reasons  
25 provided for in paragraph (4) of subdivision (f).

26 (C) The department is exercising its authority under Section  
27 14043.37, 14043.4, or 14043.7 to conduct background checks,  
28 preenrollment inspections, or unannounced visits.

29 (2) (A) If the application package that was noticed as  
30 incomplete under paragraph (2) of subdivision (f) is not resubmitted  
31 with all requested information and documentation and received  
32 by the department within 60 days of the date on the notice, the  
33 application package shall be denied by operation of law. The  
34 applicant or provider may reapply by submitting a new application  
35 package that shall be reviewed de novo.

36 (B) If the failure to resubmit is by a provider applying for  
37 continued enrollment, the failure shall make the provider also  
38 subject to deactivation of the provider's number and all of the  
39 business addresses used by the provider to provide services, goods,  
40 supplies, or merchandise to Medi-Cal beneficiaries.



(C) Notwithstanding subparagraph (A), if the notice of an incomplete application package included a request for information or documentation related to grounds for denial under Section 14043.2 or 14043.36, the applicant or provider shall not reapply for enrollment or continued enrollment in the Medi-Cal program or for participation in any health care program administered by the department or its agents or contractors for a period of three years.

(i) (1) If the department exercises its authority under Section 14043.37, 14043.4, or 14043.7 to conduct background checks, preenrollment inspections, or unannounced visits, the applicant or provider shall receive notice, from the department, after the conclusion of the background check, preenrollment inspection, or unannounced visit of either of the following:

(A) The applicant or provider is granted provisional provider status for a period of 12 months, effective from the date on the notice.

(B) Discrepancies or failure to meet program requirements, as prescribed by the department, have been found to exist during the preenrollment period.

(2) (A) The notice shall identify the discrepancies or failures, and whether remediation can be made or not, and if so, the time period within which remediation must be accomplished. Failure to remediate discrepancies and failures as prescribed by the department, or notification that remediation is not available, shall result in denial of the application by operation of law. The applicant or provider may reapply by submitting a new application package that shall be reviewed de novo.

(B) If the failure to remediate is by a provider applying for continued enrollment, the failure shall make the provider also subject to deactivation of the provider's number and all of the business addresses used by the provider to provide services, goods, supplies, or merchandise to Medi-Cal beneficiaries.

(C) Notwithstanding subparagraph (A), if the discrepancies or failure to meet program requirements, as prescribed by the director, included in the notice were related to grounds for denial under Section 14043.2 or 14043.36, the applicant or provider shall not reapply for three years.

(j) If provisional provider status or preferred provisional provider status is granted pursuant to this section, a provider number shall

1 be used by the provider for each business address for which an  
2 application package has been approved. This provider number  
3 shall be used exclusively for the locations for which it was  
4 approved, unless the practice of the provider's profession or  
5 delivery of services, goods, supplies, or merchandise is such that  
6 services, goods, supplies, or merchandise are rendered or delivered  
7 at locations other than the provider's business address and this  
8 practice or delivery of services, goods, supplies, or merchandise  
9 has been disclosed in the application package approved by the  
10 department when the provisional provider status or preferred  
11 provisional provider status was granted.

12 (k) Except for providers subject to subdivision (c) of Section  
13 14043.47, a provider currently enrolled in the Medi-Cal program  
14 at one or more locations who has submitted an application package  
15 for enrollment at a new location or a change in location pursuant  
16 to subdivision (a), or filed a change of location form pursuant to  
17 subdivision (b), may submit claims for services, goods, supplies,  
18 or merchandise rendered at the new location until the application  
19 package or change of location form is approved or denied under  
20 this section, and shall not be subject, during that period, to  
21 deactivation, or be subject to any delay or nonpayment of claims  
22 as a result of billing for services rendered at the new location as  
23 herein authorized. However, the provider shall be considered during  
24 that period to have been granted provisional provider status or  
25 preferred provisional provider status and be subject to termination  
26 of that status pursuant to Section 14043.27. A provider that is  
27 subject to subdivision (c) of Section 14043.47 may come within  
28 the scope of this subdivision upon submitting documentation in  
29 the application package that identifies the physician providing  
30 supervision for every three locations. If a provider submits claims  
31 for services rendered at a new location before the application for  
32 that location is received by the department, the department may  
33 deny the claim.

34 (l) An applicant or a provider whose application for enrollment,  
35 continued enrollment, or a new location or change in location has  
36 been denied pursuant to this section, may appeal the denial in  
37 accordance with Section 14043.65.

38 (m) (1) Upon receipt of a complete and accurate claim for an  
39 individual nurse provider, the department shall adjudicate the claim  
40 within an average of 30 days.

1 (2) During the budget proceedings of the 2006–07 fiscal year,  
2 and each fiscal year thereafter, the department shall provide data  
3 to the Legislature specifying the timeframe under which it has  
4 processed and approved the provider applications submitted by  
5 individual nurse providers.

6 (3) For purposes of this subdivision, “individual nurse providers”  
7 are providers authorized under certain home- and community-based  
8 waivers and under the state plan to provide nursing services to  
9 Medi-Cal recipients in the recipients’ own homes rather than in  
10 institutional settings.

11 (n) The amendments to subdivision (b), which implement a  
12 change of location form, and the addition of paragraph (2) to  
13 subdivision (c), the amendments to subdivision (e), and the addition  
14 of subdivision (g), which prescribe different processing timeframes  
15 for physicians and physician groups, as contained in Chapter 693  
16 of the Statutes of 2007, shall become operative on July 1, 2008.

17 (o) *This section shall become inoperative on the effective date*  
18 *of the necessary state plan amendment, as stated in the declaration*  
19 *executed by the director pursuant to Section 14043.26 as added*  
20 *by Section 10 of the act that added this subdivision, and is repealed*  
21 *on the January 1 of the following year.*

22 SEC. 10. Section 14043.26 is added to the Welfare and  
23 Institutions Code, to read:

24 14043.26. (a) (1) On and after January 1, 2004, an applicant  
25 that currently is not enrolled in the Medi-Cal program, or a provider  
26 applying for continued enrollment, upon written notification from  
27 the department that enrollment for continued participation of all  
28 providers in a specific provider of service category or subgroup  
29 of that category to which the provider belongs will occur, or, except  
30 as provided in subdivisions (b) and (e), a provider not currently  
31 enrolled at a location where the provider intends to provide  
32 services, goods, supplies, or merchandise to a Medi-Cal  
33 beneficiary, shall submit a complete application package for  
34 enrollment, continuing enrollment, or enrollment at a new location  
35 or a change in location.

36 (2) Clinics licensed by the department pursuant to Chapter 1  
37 (commencing with Section 1200) of Division 2 of the Health and  
38 Safety Code and certified by the department to participate in the  
39 Medi-Cal program shall not be subject to this section.

1 (3) Health facilities licensed by the department pursuant to  
2 Chapter 2 (commencing with Section 1250) of Division 2 of the  
3 Health and Safety Code and certified by the department to  
4 participate in the Medi-Cal program shall not be subject to this  
5 section.

6 (4) Adult day health care providers licensed pursuant to Chapter  
7 3.3 (commencing with Section 1570) of Division 2 of the Health  
8 and Safety Code and certified by the department to participate in  
9 the Medi-Cal program shall not be subject to this section.

10 (5) Home health agencies licensed pursuant to Chapter 8  
11 (commencing with Section 1725) of Division 2 of the Health and  
12 Safety Code and certified by the department to participate in the  
13 Medi-Cal program shall not be subject to this section.

14 (6) Hospices licensed pursuant to Chapter 8.5 (commencing  
15 with Section 1745) of Division 2 of the Health and Safety Code  
16 and certified by the department to participate in the Medi-Cal  
17 program shall not be subject to this section.

18 (b) A physician and surgeon licensed by the Medical Board of  
19 California or the Osteopathic Medical Board of California, or a  
20 dentist licensed by the Dental Board of California, practicing as  
21 an individual physician practice or as an individual dentist practice,  
22 as defined in Section 14043.1, who is enrolled and in good standing  
23 in the Medi-Cal program, and who is changing locations of that  
24 individual physician practice or individual dentist practice within  
25 the same county, shall be eligible to continue enrollment at the  
26 new location by filing a change of location form to be developed  
27 by the department. The form shall comply with all minimum  
28 federal requirements related to Medicaid provider enrollment.  
29 Filing this form shall be in lieu of submitting a complete  
30 application package pursuant to subdivision (a).

31 (c) (1) Except as provided in paragraph (2), within 30 days  
32 after receiving an application package submitted pursuant to  
33 subdivision (a), the department shall provide written notice that  
34 the application package has been received and, if applicable, that  
35 there is a moratorium on the enrollment of providers in the specific  
36 provider of service category or subgroup of the category to which  
37 the applicant or provider belongs. This moratorium shall bar further  
38 processing of the application package.

39 (2) Within 15 days after receiving an application package from  
40 a physician, or a group of physicians, licensed by the Medical

1 Board of California or the Osteopathic Medical Board of California,  
2 or a change of location form pursuant to subdivision (b), the  
3 department shall provide written notice that the application package  
4 or the change of location form has been received.

5 (d) (1) If the application package submitted pursuant to  
6 subdivision (a) is from an applicant or provider who meets the  
7 criteria listed in paragraph (2), the applicant or provider shall be  
8 considered a preferred provider and shall be granted preferred  
9 provisional provider status pursuant to this section and for a period  
10 of no longer than 18 months, effective from the date on the notice  
11 from the department. The ability to request consideration as a  
12 preferred provider and the criteria necessary for the consideration  
13 shall be publicized to all applicants and providers. An applicant  
14 or provider who desires consideration as a preferred provider  
15 pursuant to this subdivision shall request consideration from the  
16 department by making a notation to that effect on the application  
17 package, by cover letter, or by other means identified by the  
18 department in a provider bulletin. Request for consideration as a  
19 preferred provider shall be made with each application package  
20 submitted in order for the department to grant the consideration.  
21 An applicant or provider who requests consideration as a preferred  
22 provider shall be notified within 60 days whether the applicant or  
23 provider meets or does not meet the criteria listed in paragraph  
24 (2). If an applicant or provider is notified that the applicant or  
25 provider does not meet the criteria for a preferred provider, the  
26 application package submitted shall be processed in accordance  
27 with the remainder of this section.

28 (2) To be considered a preferred provider, the applicant or  
29 provider shall meet all of the following criteria:

30 (A) Hold a current license as a physician and surgeon issued by  
31 the Medical Board of California or the Osteopathic Medical Board  
32 of California, which license shall not have been revoked, whether  
33 stayed or not, suspended, placed on probation, or subject to other  
34 limitation.

35 (B) Be a current faculty member of a teaching hospital or a  
36 children's hospital, as defined in Section 10727, accredited by the  
37 Joint Commission or the American Osteopathic Association, or  
38 be credentialed by a health care service plan that is licensed under  
39 the Knox-Keene Health Care Service Plan Act of 1975 (Chapter  
40 2.2 (commencing with Section 1340) of Division 2 of the Health

1 and Safety Code) or county organized health system, or be a current  
2 member in good standing of a group that is credentialed by a health  
3 care service plan that is licensed under the Knox-Keene Act.

4 (C) Have full, current, unrevoked, and unsuspended privileges  
5 at a Joint Commission or American Osteopathic Association  
6 accredited general acute care hospital.

7 (D) Not have any adverse entries in the federal Healthcare  
8 Integrity and Protection Data Bank.

9 (3) The department may recognize other providers as qualifying  
10 as preferred providers if criteria similar to those set forth in  
11 paragraph (2) are identified for the other providers. The department  
12 shall consult with interested parties and appropriate stakeholders  
13 to identify similar criteria for other providers so that they may be  
14 considered as preferred providers.

15 (e) (1) If a Medi-Cal applicant meets the criteria listed in  
16 paragraph (2), the applicant shall be enrolled in the Medi-Cal  
17 program after submission and review of a short form application  
18 to be developed by the department. The form shall comply with  
19 all minimum federal requirements related to Medicaid provider  
20 enrollment. The department shall notify the applicant that the  
21 department has received the application within 15 days of receipt  
22 of the application. The department shall enroll the applicant or  
23 notify the applicant that the applicant does not meet the criteria  
24 listed in paragraph (2) within 90 days of receipt of the application.

25 (2) Notwithstanding any other provision of law, an applicant or  
26 provider who meets all of the following criteria shall be eligible  
27 for enrollment in the Medi-Cal program pursuant to this  
28 subdivision, after submission and review of a short form  
29 application:

30 (A) The applicant's or provider's practice is based in one or  
31 more of the following: a general acute care hospital, a rural general  
32 acute care hospital, or an acute psychiatric hospital, as defined in  
33 subdivisions (a) and (b) of Section 1250 of the Health and Safety  
34 Code.

35 (B) The applicant or provider holds a current, unrevoked, or  
36 unsuspended license as a physician and surgeon issued by the  
37 Medical Board of California or the Osteopathic Medical Board of  
38 California. An applicant or provider shall not be in compliance  
39 with this subparagraph if a license revocation has been stayed, the

1 licensee has been placed on probation, or the license is subject to  
2 any other limitation.

3 (C) The applicant or provider does not have an adverse entry  
4 in the federal Healthcare Integrity and Protection Data Bank.

5 (3) An applicant shall be granted provisional provider status  
6 under this subdivision for a period of 12 months.

7 (f) Except as provided in subdivision (g), within 180 days after  
8 receiving an application package submitted pursuant to subdivision  
9 (a), or from the date of the notice to an applicant or provider that  
10 the applicant or provider does not qualify as a preferred provider  
11 under subdivision (d), the department shall give written notice to  
12 the applicant or provider that any of the following applies, or shall  
13 on the 181st day grant the applicant or provider provisional  
14 provider status pursuant to this section for a period no longer than  
15 12 months, effective from the 181st day:

16 (1) The applicant or provider is being granted provisional  
17 provider status for a period of 12 months, effective from the date  
18 on the notice.

19 (2) The application package is incomplete. The notice shall  
20 identify additional information or documentation that is needed to  
21 complete the application package.

22 (3) The department is exercising its authority under Section  
23 14043.37, 14043.4, or 14043.7, and is conducting background  
24 checks, preenrollment inspections, or unannounced visits.

25 (4) The application package is denied for any of the following  
26 reasons:

27 (A) Pursuant to Section 14043.2 or 14043.36.

28 (B) For lack of a license necessary to perform the health care  
29 services or to provide the goods, supplies, or merchandise directly  
30 or indirectly to a Medi-Cal beneficiary, within the applicable  
31 provider of service category or subgroup of that category.

32 (C) The period of time during which an applicant or provider  
33 has been barred from reapplying has not passed.

34 (D) For other stated reasons authorized by law.

35 (E) For failing to submit fingerprints as required by federal  
36 Medicaid regulations.

37 (g) Notwithstanding subdivision (f), within 90 days after  
38 receiving an application package submitted pursuant to subdivision  
39 (a) from a physician or physician group licensed by the Medical  
40 Board of California or the Osteopathic Medical Board of California,

1 or from the date of the notice to that physician or physician group  
2 that does not qualify as a preferred provider under subdivision (d),  
3 or within 90 days after receiving a change of location form  
4 submitted pursuant to subdivision (b), the department shall give  
5 written notice to the applicant or provider that either paragraph  
6 (1), (2), (3), or (4) of subdivision (f) applies, or shall on the 91st  
7 day grant the applicant or provider provisional provider status  
8 pursuant to this section for a period no longer than 12 months,  
9 effective from the 91st day.

10 (h) (1) If the application package that was noticed as incomplete  
11 under paragraph (2) of subdivision (f) is resubmitted with all  
12 requested information and documentation, and received by the  
13 department within 60 days of the date on the notice, the department  
14 shall, within 60 days of the resubmission, send a notice that any  
15 of the following applies:

16 (A) The applicant or provider is being granted provisional  
17 provider status for a period of 12 months, effective from the date  
18 on the notice.

19 (B) The application package is denied for any other reasons  
20 provided for in paragraph (4) of subdivision (f).

21 (C) The department is exercising its authority under Section  
22 14043.37, 14043.4, or 14043.7 to conduct background checks,  
23 preenrollment inspections, or unannounced visits.

24 (2) (A) If the application package that was noticed as  
25 incomplete under paragraph (2) of subdivision (f) is not resubmitted  
26 with all requested information and documentation and received  
27 by the department within 60 days of the date on the notice, the  
28 application package shall be denied by operation of law. The  
29 applicant or provider may reapply by submitting a new application  
30 package that shall be reviewed de novo.

31 (B) If the failure to resubmit is by a currently enrolled provider  
32 as defined in Section 14043.1, including providers applying for  
33 continued enrollment, the failure shall make the provider also  
34 subject to deactivation of the provider's number and all of the  
35 business addresses used by the provider to provide services, goods,  
36 supplies, or merchandise to Medi-Cal beneficiaries.

37 (C) Notwithstanding subparagraph (A), if the notice of an  
38 incomplete application package included a request for information  
39 or documentation related to grounds for denial under Section  
40 14043.2 or 14043.36, the applicant or provider shall not reapply



1 for enrollment or continued enrollment in the Medi-Cal program  
2 or for participation in any health care program administered by  
3 the department or its agents or contractors for a period of three  
4 years.

5 (i) (1) If the department exercises its authority under Section  
6 14043.37, 14043.4, or 14043.7 to conduct background checks,  
7 preenrollment inspections, or unannounced visits, the applicant or  
8 provider shall receive notice, from the department, after the  
9 conclusion of the background check, preenrollment inspection, or  
10 unannounced visit of either of the following:

11 (A) The applicant or provider is granted provisional provider  
12 status for a period of 12 months, effective from the date on the  
13 notice.

14 (B) Discrepancies or failure to meet program requirements, as  
15 prescribed by the department, have been found to exist during the  
16 preenrollment period.

17 (2) (A) The notice shall identify the discrepancies or failures,  
18 and whether remediation can be made or not, and if so, the time  
19 period within which remediation must be accomplished. Failure  
20 to remediate discrepancies and failures as prescribed by the  
21 department, or notification that remediation is not available, shall  
22 result in denial of the application by operation of law. The applicant  
23 or provider may reapply by submitting a new application package  
24 that shall be reviewed de novo.

25 (B) If the failure to remediate is by a currently enrolled provider  
26 as defined in Section 14043.1, including providers applying for  
27 continued enrollment, the failure shall make the provider also  
28 subject to deactivation of the provider's number and all of the  
29 business addresses used by the provider to provide services, goods,  
30 supplies, or merchandise to Medi-Cal beneficiaries.

31 (C) Notwithstanding subparagraph (A), if the discrepancies or  
32 failure to meet program requirements, as prescribed by the director,  
33 included in the notice were related to grounds for denial under  
34 Section 14043.2 or 14043.36, the applicant or provider shall not  
35 reapply for three years.

36 (j) If provisional provider status or preferred provisional provider  
37 status is granted pursuant to this section, a provider number shall  
38 be used by the provider for each business address for which an  
39 application package has been approved. This provider number  
40 shall be used exclusively for the locations for which it was

1 approved, unless the practice of the provider's profession or  
2 delivery of services, goods, supplies, or merchandise is such that  
3 services, goods, supplies, or merchandise are rendered or delivered  
4 at locations other than the provider's business address and this  
5 practice or delivery of services, goods, supplies, or merchandise  
6 has been disclosed in the application package approved by the  
7 department when the provisional provider status or preferred  
8 provisional provider status was granted.

9 (k) Except for providers subject to subdivision (c) of Section  
10 14043.47, a provider currently enrolled in the Medi-Cal program  
11 at one or more locations who has submitted an application package  
12 for enrollment at a new location or a change in location pursuant  
13 to subdivision (a), or filed a change of location form pursuant to  
14 subdivision (b), may submit claims for services, goods, supplies,  
15 or merchandise rendered at the new location until the application  
16 package or change of location form is approved or denied under  
17 this section, and shall not be subject, during that period, to  
18 deactivation, or be subject to any delay or nonpayment of claims  
19 as a result of billing for services rendered at the new location as  
20 herein authorized. However, the provider shall be considered during  
21 that period to have been granted provisional provider status or  
22 preferred provisional provider status and be subject to termination  
23 of that status pursuant to Section 14043.27. A provider that is  
24 subject to subdivision (c) of Section 14043.47 may come within  
25 the scope of this subdivision upon submitting documentation in  
26 the application package that identifies the physician providing  
27 supervision for every three locations. If a provider submits claims  
28 for services rendered at a new location before the application for  
29 that location is received by the department, the department may  
30 deny the claim.

31 (l) An applicant or a provider whose application for enrollment,  
32 continued enrollment, or a new location or change in location has  
33 been denied pursuant to this section, may appeal the denial in  
34 accordance with Section 14043.65.

35 (m) (1) Upon receipt of a complete and accurate claim for an  
36 individual nurse provider, the department shall adjudicate the claim  
37 within an average of 30 days.

38 (2) During the budget proceedings of the 2006–07 fiscal year,  
39 and each fiscal year thereafter, the department shall provide data  
40 to the Legislature specifying the timeframe under which it has

1 processed and approved the provider applications submitted by  
2 individual nurse providers.

3 (3) For purposes of this subdivision, “individual nurse providers”  
4 are providers authorized under certain home- and community-based  
5 waivers and under the state plan to provide nursing services to  
6 Medi-Cal recipients in the recipients’ own homes rather than in  
7 institutional settings.

8 (n) The amendments to subdivision (b), which implement a  
9 change of location form, and the addition of paragraph (2) to  
10 subdivision (c), the amendments to subdivision (e), and the addition  
11 of subdivision (g), which prescribe different processing timeframes  
12 for physicians and physician groups, as contained in Chapter 693  
13 of the Statutes of 2007, shall become operative on July 1, 2008.

14 (o) (1) This section shall become operative on the effective  
15 date of the state plan amendment necessary to implement this  
16 section, as stated in the declaration executed by the director  
17 pursuant to paragraph (2).

18 (2) Upon approval of the state plan amendment necessary to  
19 implement this section under Sections 455.434 and 455.450 of  
20 Title 42 of the Code of Federal Regulations, the director shall  
21 execute a declaration, to be retained by the director, that states that  
22 this approval has been obtained and the effective date of the state  
23 plan amendment.

24 SEC. 11. Section 14043.28 of the Welfare and Institutions  
25 Code is amended to read:

26 14043.28. (a) (1) If an application package is denied under  
27 Section 14043.26 or provisional provider status or preferred  
28 provisional provider status is terminated under Section 14043.27,  
29 the applicant or provider shall be prohibited from reapplying for  
30 enrollment or continued enrollment in the Medi-Cal program or  
31 for participation in any health care program administered by the  
32 department or its agents or contractors for a period of three years  
33 from the date the application package is denied or the provisional  
34 provider status is terminated, except as provided otherwise in  
35 paragraph (2) of subdivision (h), or paragraph (2) of subdivision  
36 (i), of Section 14043.26 and as set forth in this section.

37 (2) If the application is denied under paragraph (2) of  
38 subdivision (h) of Section 14043.26 because the applicant failed  
39 to resubmit an incomplete application package or is denied under  
40 paragraph (2) of subdivision (i) of Section 14043.26 because the

1 applicant failed to remediate discrepancies, the applicant may  
2 resubmit an application in accordance with paragraph (2) of  
3 subdivision (h) or paragraph (2) of subdivision (i), respectively.

4 (3) If the denial of the application package is based upon a  
5 conviction for any offense or for any act included in Section  
6 14043.36 or termination of the provisional provider status or  
7 preferred provisional provider status is based upon a conviction  
8 for any offense or for any act included in paragraph (1) of  
9 subdivision (c) of Section 14043.27, the applicant or provider shall  
10 be prohibited from reapplying for enrollment or continued  
11 enrollment in the Medi-Cal program or for participation in any  
12 health care program administered by the department or its agents  
13 or contractors for a period of 10 years from the date the application  
14 package is denied or the provisional provider status or preferred  
15 provisional provider status is terminated.

16 (4) If the denial of the application package is based upon two  
17 or more convictions for any offense or for any two or more acts  
18 included in Section 14043.36 or termination of the provisional  
19 provider status or preferred provisional provider status is based  
20 upon two or more convictions for any offense or for any two acts  
21 included in paragraph (1) of subdivision (c) of Section 14043.27,  
22 the applicant or provider shall be permanently barred from  
23 enrollment or continued enrollment in the Medi-Cal program or  
24 for participation in any health care program administered by the  
25 department or its agents or contractors.

26 (5) The prohibition in paragraph (1) against reapplying for three  
27 years shall not apply if the denial of the application or termination  
28 of provisional provider status or preferred provisional provider  
29 status is based upon any of the following:

30 (A) The grounds provided for in paragraph (4), or subparagraph  
31 (B) of paragraph (7), of subdivision (c) of Section 14043.27.

32 (B) The grounds provided for in subdivision (d) of Section  
33 14043.27, if the investigation is closed without any adverse action  
34 being taken.

35 (C) The grounds provided for in paragraph (6) of subdivision  
36 (c) of Section 14043.27. However, the department may deny  
37 reimbursement for claims submitted while the provider was  
38 noncompliant with CLIA.

39 (b) (1) If an application package is denied under subparagraph  
40 (A), (B), or (D) of paragraph (4) of subdivision (f) of Section

14043.26, or with respect to a provider described in subparagraph (B) of paragraph (2) of subdivision (h), or subparagraph (B) of paragraph (2) of subdivision (i), of Section 14043.26, or provisional provider status or preferred provisional provider status is terminated based upon any of the grounds stated in subparagraph (A) of paragraph (7), or paragraphs (1), (2), (3), (5), and (8) to (12), inclusive, of subdivision (c) of Section 14043.27, all business addresses of the applicant or provider shall be deactivated and the applicant or provider shall be removed from enrollment in the Medi-Cal program by operation of law.

(2) If the termination of provisional provider status is based upon the grounds stated in subdivision (d) of Section 14043.27 and the investigation is closed without any adverse action being taken, or is based upon the grounds in subparagraph (B) of paragraph (7) of subdivision (c) of Section 14043.27 and the applicant or provider obtains the appropriate license, permits, or approvals covering the period of provisional provider status, the termination taken pursuant to subdivision (c) of Section 14043.27 shall be rescinded, the previously deactivated provider numbers shall be reactivated, and the provider shall be reenrolled in the Medi-Cal program, unless there are other grounds for taking these actions.

(c) Claims that are submitted or caused to be submitted by an applicant or provider who has been suspended from the Medi-Cal program for any reason or who has had its provisional provider status terminated or had its application package for enrollment or continued enrollment denied and all business addresses deactivated may not be paid for services, goods, merchandise, or supplies rendered to Medi-Cal beneficiaries during the period of suspension or termination or after the date all business addresses are deactivated.

*(d) This section shall become inoperative on the effective date of the necessary state plan amendment, as stated in the declaration executed by the director pursuant to Section 14043.28 as added by Section 12 of the act that added this subdivision, and is repealed on the January 1 of the following year.*

SEC. 12. Section 14043.28 is added to the Welfare and Institutions Code, to read:

14043.28. (a) (1) If an application package is denied under Section 14043.26 or provisional provider status or preferred

1 provisional provider status is terminated under Section 14043.27,  
2 the applicant or provider shall be prohibited from reapplying for  
3 enrollment or continued enrollment in the Medi-Cal program or  
4 for participation in any health care program administered by the  
5 department or its agents or contractors for a period of three years  
6 from the date the application package is denied or the provisional  
7 provider status is terminated, except as provided otherwise in  
8 paragraph (2) of subdivision (h), or paragraph (2) of subdivision  
9 (i), of Section 14043.26 and as set forth in this section.

10 (2) If the application is denied under paragraph (2) of  
11 subdivision (h) of Section 14043.26 because the applicant failed  
12 to resubmit an incomplete application package or is denied under  
13 paragraph (2) of subdivision (i) of Section 14043.26 because the  
14 applicant failed to remediate discrepancies, the applicant may  
15 resubmit an application in accordance with paragraph (2) of  
16 subdivision (h) or paragraph (2) of subdivision (i), respectively.

17 (3) If the denial of the application package is based upon a  
18 conviction for any offense or for any act included in Section  
19 14043.36 or termination of the provisional provider status or  
20 preferred provisional provider status is based upon a conviction  
21 for any offense or for any act included in paragraph (1) of  
22 subdivision (c) of Section 14043.27, the applicant or provider shall  
23 be prohibited from reapplying for enrollment or continued  
24 enrollment in the Medi-Cal program or for participation in any  
25 health care program administered by the department or its agents  
26 or contractors for a period of 10 years from the date the application  
27 package is denied or the provisional provider status or preferred  
28 provisional provider status is terminated.

29 (4) If the denial of the application package is based upon two  
30 or more convictions for any offense or for any two or more acts  
31 included in Section 14043.36 or termination of the provisional  
32 provider status or preferred provisional provider status is based  
33 upon two or more convictions for any offense or for any two acts  
34 included in paragraph (1) of subdivision (c) of Section 14043.27,  
35 the applicant or provider shall be permanently barred from  
36 enrollment or continued enrollment in the Medi-Cal program or  
37 for participation in any health care program administered by the  
38 department or its agents or contractors.

39 (5) The prohibition in paragraph (1) against reapplying for three  
40 years shall not apply if the denial of the application or termination

1 of provisional provider status or preferred provisional provider  
2 status is based upon any of the following:

3 (A) The grounds provided for in paragraph (4), or subparagraph  
4 (B) of paragraph (7), of subdivision (c) of Section 14043.27.

5 (B) The grounds provided for in subdivision (d) of Section  
6 14043.27, if the investigation is closed without any adverse action  
7 being taken.

8 (C) The grounds provided for in paragraph (6) of subdivision  
9 (c) of Section 14043.27. However, the department may deny  
10 reimbursement for claims submitted while the provider was  
11 noncompliant with CLIA.

12 (b) (1) If an application package is denied under subparagraph  
13 (A), (B), (D), or (E) of paragraph (4) of subdivision (f) of Section  
14 14043.26, or with respect to a provider described in subparagraph  
15 (B) of paragraph (2) of subdivision (h), or subparagraph (B) of  
16 paragraph (2) of subdivision (i), of Section 14043.26, or provisional  
17 provider status or preferred provisional provider status is terminated  
18 based upon any of the grounds stated in subparagraph (A) of  
19 paragraph (7), or paragraphs (1), (2), (3), (5), and (8) to (12),  
20 inclusive, of subdivision (c) of Section 14043.27, all business  
21 addresses of the applicant or provider shall be deactivated and the  
22 applicant or provider shall be removed from enrollment in the  
23 Medi-Cal program by operation of law.

24 (2) If the termination of provisional provider status is based  
25 upon the grounds stated in subdivision (d) of Section 14043.27  
26 and the investigation is closed without any adverse action being  
27 taken, or is based upon the grounds in subparagraph (B) of  
28 paragraph (7) of subdivision (c) of Section 14043.27 and the  
29 applicant or provider obtains the appropriate license, permits, or  
30 approvals covering the period of provisional provider status, the  
31 termination taken pursuant to subdivision (c) of Section 14043.27  
32 shall be rescinded, the previously deactivated provider numbers  
33 shall be reactivated, and the provider shall be reenrolled in the  
34 Medi-Cal program, unless there are other grounds for taking these  
35 actions.

36 (c) Claims that are submitted or caused to be submitted by an  
37 applicant or provider who has been suspended from the Medi-Cal  
38 program for any reason or who has had its provisional provider  
39 status terminated or had its application package for enrollment or  
40 continued enrollment denied and all business addresses deactivated

1 may not be paid for services, goods, merchandise, or supplies  
2 rendered to Medi-Cal beneficiaries during the period of suspension  
3 or termination or after the date all business addresses are  
4 deactivated.

5 (d) (1) This section shall become operative on the effective  
6 date of the state plan amendment necessary to implement this  
7 section, as stated in the declaration executed by the director  
8 pursuant to paragraph (2).

9 (2) Upon approval of the state plan amendment necessary to  
10 implement this section under Sections 455.434 and 455.450 of  
11 Title 42 of the Code of Federal Regulations, the director shall  
12 execute a declaration, to be retained by the director, that states that  
13 this approval has been obtained and the effective date of the state  
14 plan amendment.

15 SEC. 13. Section 14043.36 of the Welfare and Institutions  
16 Code is amended to read:

17 14043.36. (a) The department shall not enroll any applicant  
18 that has been convicted of any felony or misdemeanor involving  
19 fraud or abuse in any government program, or related to neglect  
20 or abuse of a patient in connection with the delivery of a health  
21 care item or service, or in connection with the interference with  
22 or obstruction of any investigation into health care related fraud  
23 or abuse or that has been found liable for fraud or abuse in any  
24 civil proceeding, or that has entered into a settlement in lieu of  
25 conviction for fraud or abuse in any government program, within  
26 the previous 10 years. In addition, the department may deny  
27 enrollment to any applicant that, at the time of application, is under  
28 investigation by the department or any state, local, or federal  
29 government law enforcement agency for fraud or abuse pursuant  
30 to Subpart A (commencing with Section 455.12) of Part 455 of  
31 Title 42 of the Code of Federal Regulations. The department shall  
32 not deny enrollment to an otherwise qualified applicant whose  
33 felony or misdemeanor charges did not result in a conviction solely  
34 on the basis of the prior charges. If it is discovered that a provider  
35 is under investigation by the department or any state, local, or  
36 federal government law enforcement agency for fraud or abuse,  
37 that provider shall be subject to temporary suspension from the  
38 Medi-Cal program, which shall include temporary deactivation of  
39 the provider's number, including all business addresses used by  
40 the provider to obtain reimbursement from the Medi-Cal program.



1 (b) The director shall notify in writing the provider of the  
2 temporary suspension and deactivation of the provider's number,  
3 which shall take effect 15 days from the date of the notification.  
4 Notwithstanding Section 100171 of the Health and Safety Code,  
5 proceedings after the imposition of sanctions provided for in  
6 subdivision (a) shall be in accordance with Section 14043.65.

7 (c) *A temporary suspension may be lifted when a resolution of*  
8 *an investigation for fraud or abuse occurs.*

9 (d) *This section shall become inoperative on the effective date*  
10 *of the necessary state plan amendment, as stated in the declaration*  
11 *executed by the director pursuant to Section 14043.36 as added*  
12 *by Section 14 of the act that added this subdivision, and is repealed*  
13 *on the January 1 of the following year.*

14 SEC. 14. Section 14043.36 is added to the Welfare and  
15 Institutions Code, to read:

16 14043.36. (a) The department shall not enroll any applicant  
17 that has been convicted of any felony or misdemeanor involving  
18 fraud or abuse in any government program, or related to neglect  
19 or abuse of a patient in connection with the delivery of a health  
20 care item or service, or in connection with the interference with  
21 or obstruction of any investigation into health care related fraud  
22 or abuse or that has been found liable for fraud or abuse in any  
23 civil proceeding, or that has entered into a settlement in lieu of  
24 conviction for fraud or abuse in any government program, within  
25 the previous 10 years. In addition, the department may deny  
26 enrollment to any applicant that, at the time of application, is under  
27 investigation by the department or any state, local, or federal  
28 government law enforcement agency for fraud or abuse pursuant  
29 to Subpart A (commencing with Section 455.12) of Part 455 of  
30 Title 42 of the Code of Federal Regulations. The department shall  
31 not deny enrollment to an otherwise qualified applicant whose  
32 felony or misdemeanor charges did not result in a conviction solely  
33 on the basis of the prior charges. If it is discovered that a provider  
34 is under investigation by the department or any state, local, or  
35 federal government law enforcement agency for fraud or abuse,  
36 that provider shall be subject to temporary suspension from the  
37 Medi-Cal program, which shall include temporary deactivation of  
38 the provider's number, including all business addresses used by  
39 the provider to obtain reimbursement from the Medi-Cal program.

(b) If it is discovered that a provider has been terminated under Medicare or under the Medicaid Program or Children's Health Insurance Program in any state, the provider shall not be enrolled in, or shall be subject to termination from, the Medi-Cal program, which shall include deactivation of the provider's enrolled numbers and all business addresses used to obtain reimbursement from the Medi-Cal program.

(c) The director shall notify in writing the provider of the temporary suspension and deactivation of the provider's number, which shall take effect 15 days from the date of the notification. Notwithstanding Section 100171 of the Health and Safety Code, proceedings after the imposition of sanctions provided for in subdivision (a) shall be in accordance with Section 14043.65.

(d) A temporary suspension may be lifted when a resolution of an investigation for fraud or abuse occurs.

(e) (1) This section shall become operative on the effective date of the state plan amendment necessary to implement this section, as stated in the declaration executed by the director pursuant to paragraph (2).

(2) Upon approval of the state plan amendment necessary to implement this section under Section 455.416 of Title 42 of the Code of Federal Regulations, the director shall execute a declaration, to be retained by the director, that states that this approval has been obtained and the effective date of the state plan amendment.

SEC. 15. Section 14043.38 is added to the Welfare and Institutions Code, to read:

14043.38. (a) If the department designates a provider as a "high" categorical risk, the department shall conduct a criminal background check and shall require submission of a set of fingerprints in accordance with Section 13000 of the Penal Code. If fingerprints are required, providers and any person with a 5-percent direct or indirect ownership interest in the provider shall be required to submit fingerprints in a manner determined by the department within 30 days of the request.

(b) In designating a provider's categorical risk, the department may utilize the "high" categorical risk provider types designated in Section 424.518 of Title 42 of the Code of Federal Regulations.

1 (c) In accordance with Section 455.450 of Title 42 of the Code  
2 of Federal Regulations, the department shall designate a provider  
3 as a “high” categorical risk if any of the following occur:

4 (1) The department imposes a payment suspension based on a  
5 credible allegation of fraud, waste, or abuse.

6 (2) The provider has an existing Medicaid overpayment.

7 (3) The provider has been excluded by the federal Office of the  
8 Inspector General or another state’s Medicaid program within the  
9 previous 10 years.

10 (4) The federal Centers for Medicare and Medicaid Services  
11 lifted a temporary moratorium within the previous six months for  
12 the particular provider type submitting the application, the applicant  
13 would have been prevented from enrolling based on that previous  
14 moratorium, and the applicant applies for enrollment as a provider  
15 at any time within six months from the date the moratorium was  
16 lifted.

17 (d) (1) This section shall become operative on the effective  
18 date of the state plan amendment necessary to implement this  
19 section, as stated in the declaration executed by the director  
20 pursuant to paragraph (2).

21 (2) Upon approval of the state plan amendment necessary to  
22 implement this section under Sections 424.518, 455.434, and  
23 455.450 of Title 42 of the Code of Federal Regulations, the director  
24 shall execute a declaration, to be retained by the director, that states  
25 that this approval has been obtained and the effective date of the  
26 state plan amendment.

27 SEC. 16. Section 14043.4 of the Welfare and Institutions Code  
28 is amended to read:

29 14043.4. (a) If discrepancies are found to exist during the  
30 preenrollment period, the department may conduct additional  
31 inspections prior to enrollment. Failure to remediate discrepancies  
32 as prescribed by the director may result in denial of the application  
33 for enrollment.

34 (b) *This section shall become inoperative on the effective date*  
35 *of the necessary state plan amendment, as stated in the declaration*  
36 *executed by the director pursuant to Section 14043.4 as added by*  
37 *Section 17 of the act that added this subdivision, and is repealed*  
38 *on the January 1 of the following year.*

39 SEC. 17. Section 14043.4 is added to the Welfare and  
40 Institutions Code, to read:

1 14043.4. (a) If discrepancies are found to exist during the  
2 preenrollment period, the department may conduct additional  
3 inspections prior to enrollment. Failure of a provider to remediate  
4 discrepancies as prescribed by the director may result in denial of  
5 the application for enrollment and deactivation of all of the  
6 provider's business addresses.

7 (b) (1) This section shall become operative on the effective  
8 date of the state plan amendment necessary to implement this  
9 section, as stated in the declaration executed by the director  
10 pursuant to paragraph (2).

11 (2) Upon approval of the state plan amendment necessary to  
12 implement this section under Section 455.416 of Title 42 of the  
13 Code of Federal Regulations, the director shall execute a  
14 declaration, to be retained by the director, that states that this  
15 approval has been obtained and the effective date of the state plan  
16 amendment.

17 SEC. 18. Section 14043.55 of the Welfare and Institutions  
18 Code is amended to read:

19 14043.55. (a) The department may implement a 180-day  
20 moratorium on the enrollment of providers in a specific provider  
21 of service category, on a statewide basis or within a geographic  
22 area, except that no moratorium shall be implemented on the  
23 enrollment of providers who are licensed as clinics under Section  
24 1204 of the Health and Safety Code, health facilities under Chapter  
25 2 (commencing with Section 1250) of the Health and Safety Code,  
26 clinics exempt from licensure under Section 1206 of the Health  
27 and Safety Code, or natural persons licensed or certified under  
28 Division 2 (commencing with Section 500) of the Business and  
29 Professions Code, the Osteopathic Initiative Act, or the  
30 Chiropractic Initiative Act, when the director determines this action  
31 is necessary to safeguard public funds or to maintain the fiscal  
32 integrity of the program. This moratorium may be extended or  
33 repeated when the director determines this action is necessary to  
34 safeguard public funds or to maintain the fiscal integrity of the  
35 program. The authority granted in this section shall not be  
36 interpreted as a limitation on the authority granted to the  
37 department in Section 14105.3.

38 (b) *This section shall become inoperative on the effective date*  
39 *of the necessary state plan amendment, as stated in the declaration*  
40 *executed by the director pursuant to Section 14043.55 as added*

1 *by Section 19 of the act that added this subdivision, and is repealed*  
2 *on the January 1 of the following year.*

3 SEC. 19. Section 14043.55 is added to the Welfare and  
4 Institutions Code, to read:

5 14043.55. (a) The department may implement a 180-day  
6 moratorium on the enrollment of providers in a specific provider  
7 of service category, on a statewide basis or within a geographic  
8 area, except that no moratorium shall be implemented on the  
9 enrollment of providers who are licensed as clinics under Section  
10 1204 of the Health and Safety Code, health facilities under Chapter  
11 2 (commencing with Section 1250) of the Health and Safety Code,  
12 clinics exempt from licensure under Section 1206 of the Health  
13 and Safety Code, or natural persons licensed or certified under  
14 Division 2 (commencing with Section 500) of the Business and  
15 Professions Code, the Osteopathic Initiative Act, or the  
16 Chiropractic Initiative Act, when the director determines this action  
17 is necessary to safeguard public funds or to maintain the fiscal  
18 integrity of the program. This moratorium may be extended or  
19 repeated when the director determines this action is necessary to  
20 safeguard public funds or to maintain the fiscal integrity of the  
21 program. The authority granted in this section shall not be  
22 interpreted as a limitation on the authority granted to the  
23 department in Section 14105.3.

24 (b) If the Secretary of the United States Department of Health  
25 and Human Services establishes a temporary moratorium on  
26 enrollment as described in federal regulations, the department shall  
27 establish a corresponding moratorium covering the same period  
28 and provider types, even if those provider types would not  
29 ordinarily be subject to a moratorium under this section, unless  
30 the department determines that the imposition of the moratorium  
31 will adversely impact beneficiaries access to medical assistance.  
32 A moratorium adopted under this subdivision shall not be subject  
33 to any of the determinations or prerequisites required of a  
34 state-initiated moratorium.

35 (c) (1) This section shall become operative on the effective date  
36 of the state plan amendment necessary to implement this section,  
37 as stated in the declaration executed by the director pursuant to  
38 paragraph (2).

39 (2) Upon approval of the state plan amendment necessary to  
40 implement this section under Section 455.470 of Title 42 of the

1 Code of Federal Regulations, the director shall execute a  
2 declaration, to be retained by the director, that states that this  
3 approval has been obtained and the effective date of the state plan  
4 amendment.

5 SEC. 20. Section 14043.65 of the Welfare and Institutions  
6 Code is amended to read:

7 14043.65. (a) Notwithstanding any other ~~provision of~~ law,  
8 any applicant whose application for enrollment as a provider or  
9 whose certification is denied; or any provider who is denied  
10 continued enrollment or certification, or denied enrollment for a  
11 new location, who has been temporarily suspended, who has had  
12 ~~payments withheld~~ *suspended*, who has had one or more business  
13 addresses used to obtain reimbursement from the Medi-Cal  
14 program deactivated, or whose provisional provider status or  
15 preferred provisional provider status has been terminated pursuant  
16 to this article or Section 14107.11, or Section 100185.5 of the  
17 Health and Safety Code, or who has had a civil penalty imposed  
18 pursuant to subdivision (a) of Section 14123.25; or any billing  
19 agent, as defined in Section 14040, when the billing agent's  
20 registration has been denied pursuant to subdivision (e) of Section  
21 14040.5, may appeal this action by submitting a written appeal,  
22 including any supporting evidence, to the director or the director's  
23 designee. ~~Where~~ *If* the appeal is of a ~~withholding~~ *suspension* of  
24 payment pursuant to Section 14107.11, the appeal to the director  
25 or the director's designee shall be limited to the issue of the  
26 reliability of the evidence supporting the ~~withhold~~ *payment*  
27 *suspension* and shall not encompass fraud or abuse. The appeal  
28 procedure shall not include a formal administrative hearing under  
29 the Administrative Procedure Act and shall not result in  
30 reactivation of any deactivated provider numbers during appeal.  
31 An applicant, provider, or billing agent that files an appeal pursuant  
32 to this section shall submit the written appeal along with all  
33 pertinent documents and all other relevant evidence to the director  
34 or to the director's designee within 60 days of the date of  
35 notification of the department's action. The director or the  
36 director's designee shall review all of the relevant materials  
37 submitted and shall issue a decision within 90 days of the receipt  
38 of the appeal. The decision may provide that the action taken  
39 should be upheld, continued, or reversed, in whole or in part. The  
40 decision of the director or the director's designee shall be final.

1 Any further appeal shall be required to be filed in accordance with  
2 Section 1085 of the Code of Civil Procedure.

3 (b) No applicant whose application for enrollment as a provider  
4 has been denied pursuant to Section 14043.2, 14043.36, or 14043.4  
5 may reapply for a period of three years from the date the  
6 application is denied. The three-year period shall commence upon  
7 the date of the denial notice.

8 SEC. 21. Section 14043.7 of the Welfare and Institutions Code  
9 is amended to read:

10 14043.7. (a) The department may make unannounced visits  
11 to any applicant or to any provider for the purpose of determining  
12 whether enrollment, continued enrollment, or certification is  
13 warranted, or as necessary for the administration of the Medi-Cal  
14 program. At the time of the visit, the applicant or provider shall  
15 be required to demonstrate an established place of business  
16 appropriate and adequate for the services billed or claimed to the  
17 Medi-Cal program, as relevant to his or her scope of practice, as  
18 indicated by, but not limited to, the following:

- 19 (1) Being open and available to the general public.
- 20 (2) Having regularly established and posted business hours.
- 21 (3) Having adequate supplies in stock on the premises.
- 22 (4) Meeting all local laws and ordinances regarding business  
23 licensing and operations.
- 24 (5) Having the necessary equipment and facilities to carry out  
25 day-to-day business for his or her practice.

26 (b) An unannounced visit pursuant to subdivision (a) shall be  
27 prohibited with respect to clinics licensed under Section 1204 of  
28 the Health and Safety Code, clinics exempt from licensure under  
29 Section 1206 of the Health and Safety Code, health facilities  
30 licensed under Chapter 2 (commencing with Section 1250) of  
31 Division 2 of the Health and Safety Code, and natural persons  
32 licensed or certified under Division 2 (commencing with Section  
33 500) of the Business and Professions Code, the Osteopathic  
34 Initiative Act, or the Chiropractic Initiative Act, unless the  
35 department has reason to believe that the provider will defraud or  
36 abuse the Medi-Cal program or lacks the organizational or  
37 administrative capacity to provide services under the program.

38 (c) Failure to remediate significant discrepancies in information  
39 provided to the department by the provider or significant  
40 discrepancies that are discovered as a result of an announced or

1 unannounced visit to a provider, for purposes of enrollment,  
2 continued enrollment, or certification pursuant to subdivision (a)  
3 shall make the provider subject to temporary suspension from the  
4 Medi-Cal program, which shall include temporary deactivation of  
5 the provider's number, including all business addresses used by  
6 the provider to obtain reimbursement from the Medi-Cal program.  
7 The director shall notify in writing the provider of the temporary  
8 suspension and deactivation of provider numbers, which shall take  
9 effect 15 days from the date of the notification. Notwithstanding  
10 Section 100171 of the Health and Safety Code, proceedings after  
11 the imposition of sanctions in this paragraph shall be in accordance  
12 with Section 14043.65.

13 *(d) This section shall become inoperative on the effective date*  
14 *of the necessary state plan amendment, as stated in the declaration*  
15 *executed by the director pursuant to Section 14043.7 as added by*  
16 *Section 22 of the act that added this subdivision, and is repealed*  
17 *on the January 1 of the following year.*

18 SEC. 22. Section 14043.7 is added to the Welfare and  
19 Institutions Code, to read:

20 14043.7. (a) The department may make unannounced visits  
21 to any applicant or to any provider for the purpose of determining  
22 whether enrollment, continued enrollment, or certification is  
23 warranted, or as necessary for the administration of the Medi-Cal  
24 program. If an unannounced site visit is conducted by the  
25 department for any enrolled provider, the provider shall permit  
26 access to any and all of their provider locations. If a provider fails  
27 to permit access for any site visit, the application shall be denied  
28 and the provider shall be subject to deactivation. At the time of  
29 the visit, the applicant or provider shall be required to demonstrate  
30 an established place of business appropriate and adequate for the  
31 services billed or claimed to the Medi-Cal program, as relevant to  
32 his or her scope of practice, as indicated by, but not limited to, the  
33 following:

- 34 (1) Being open and available to the general public.  
35 (2) Having regularly established and posted business hours.  
36 (3) Having adequate supplies in stock on the premises.  
37 (4) Meeting all local laws and ordinances regarding business  
38 licensing and operations.  
39 (5) Having the necessary equipment and facilities to carry out  
40 day-to-day business for his or her practice.



(b) An unannounced visit pursuant to subdivision (a) shall be prohibited with respect to clinics licensed under Section 1204 of the Health and Safety Code, clinics exempt from licensure under Section 1206 of the Health and Safety Code, health facilities licensed under Chapter 2 (commencing with Section 1250) of Division 2 of the Health and Safety Code, and natural persons licensed or certified under Division 2 (commencing with Section 500) of the Business and Professions Code, the Osteopathic Initiative Act, or the Chiropractic Initiative Act, unless the department has reason to believe that the provider will defraud or abuse the Medi-Cal program or lacks the organizational or administrative capacity to provide services under the program.

(c) Failure to remediate significant discrepancies in information provided to the department by the provider or significant discrepancies that are discovered as a result of an announced or unannounced visit to a provider, for purposes of enrollment, continued enrollment, or certification pursuant to subdivision (a) shall make the provider subject to temporary suspension from the Medi-Cal program, which shall include deactivation of the provider's number, including all business addresses used by the provider to obtain reimbursement from the Medi-Cal program. The director shall notify in writing the provider of the temporary suspension and deactivation of provider numbers, which shall take effect 15 days from the date of the notification. Notwithstanding Section 100171 of the Health and Safety Code, proceedings after the imposition of sanctions in this paragraph shall be in accordance with Section 14043.65.

(d) (1) This section shall become operative on the effective date of the state plan amendment necessary to implement this section, as stated in the declaration executed by the director pursuant to paragraph (2).

(2) Upon approval of the state plan amendment necessary to implement this section under Section 455.416 of Title 42 of the Code of Federal Regulations, the director shall execute a declaration, to be retained by the director, that states that this approval has been obtained and the effective date of the state plan amendment.

SEC. 23. Section 14043.75 of the Welfare and Institutions Code is amended to read:

1 14043.75. (a) The director may, in consultation with interested  
2 parties, by regulation, adopt, readopt, repeal, or amend additional  
3 measures to prevent or curtail fraud and abuse. Regulations  
4 adopted, readopted, repealed, or amended pursuant to this section  
5 shall be deemed emergency regulations in accordance with the  
6 Administrative Procedure Act (Chapter 3.5 (commencing with  
7 Section 11340) of Part 1 of Division 3 of Title 2 of the Government  
8 Code). These emergency regulations shall be deemed necessary  
9 for the immediate preservation of the public peace, health and  
10 safety, or general welfare. Emergency regulations adopted,  
11 amended, or repealed pursuant to this section shall be exempt from  
12 review by the Office of Administrative Law. The emergency  
13 regulations authorized by this section shall be submitted to the  
14 Office of Administrative Law for filing with the Secretary of State  
15 and publication in the California Code of Regulations.

16 (b) Notwithstanding any other ~~provision of~~ law, the director  
17 may, without taking regulatory action pursuant to Chapter 3.5  
18 (commencing with Section 11340) of Part 1 of Division 3 of Title  
19 2 of the Government Code, implement, interpret, or make specific  
20 Sections 14043.15, ~~14043.25~~, 14043.26, 14043.27, 14043.28,  
21 14043.29, and 14043.341 by means of a provider bulletin or similar  
22 instruction. The department shall notify and consult with interested  
23 parties and appropriate stakeholders in implementing, interpreting,  
24 or making specific those provisions described in this subdivision,  
25 including all of the following:

26 (1) Notifying provider representatives of the proposed action  
27 or change. The notice shall occur at least 10 business days prior  
28 to the meeting provided for in paragraph (2).

29 (2) Scheduling at least one meeting with interested parties and  
30 appropriate stakeholders to discuss the action or change.

31 (3) Allowing for written input regarding the action or change.

32 (4) Providing at least 30 days' advance notice of the effective  
33 date of the action or change.

34 SEC. 24. Section 14107.11 of the Welfare and Institutions  
35 Code is amended to read:

36 14107.11. (a) Upon receipt of ~~reliable evidence that would be~~  
37 ~~admissible under the administrative adjudication provisions of~~  
38 ~~Chapter 5 (commencing with Section 11500) of Part 1 of Division~~  
39 ~~3 of Title 2 of the Government Code, of fraud or willful~~  
40 ~~misrepresentation by a credible allegation of fraud against a~~

1 provider as defined in Section 14043.1, under the Medi-Cal  
2 program or the commencement of a suspension under Section  
3 14123, the *provider shall be temporarily placed under payment*  
4 *suspension, unless it is determined there is a good cause exception,*  
5 *as defined in subdivision (g), not to suspend the payments or to*  
6 *suspend them only in part, and the department may do any of the*  
7 *following:*

8 (1) Collect any Medi-Cal program overpayment identified  
9 through an audit or examination, or any portion thereof from any  
10 provider. Notwithstanding Section 100171 of the Health and Safety  
11 Code, a provider may appeal the collection of overpayments under  
12 this section pursuant to procedures established in Article 5.3  
13 (commencing with Section 14170). Overpayments collected under  
14 this section shall not be returned to the provider during the  
15 pendency of any appeal and may be offset to satisfy audit or appeal  
16 findings if the findings are against the provider. Overpayments  
17 will be returned to a provider with interest if findings are in favor  
18 of the provider.

19 (2) ~~Withhold payment~~ *Give notification of the payment*  
20 *suspension for any goods, services, supplies, or merchandise, or*  
21 *any portion thereof. The department shall notify the provider within*  
22 *five days of any withholding of payment suspension under this*  
23 *section. The department may delay notification to the provider by*  
24 *30 days if it is requested to do so in writing by any law enforcement*  
25 *agency, which may be renewed in writing up to two times and in*  
26 *no event may exceed 90 days. The notice to the provider shall do*  
27 *all of the following:*

28 (A) ~~State that payments are being withheld~~ *the payment*  
29 *suspension is being imposed in accordance with this subdivision*  
30 *and that the withholding payment suspension is for a temporary*  
31 *period and will not continue after if it is determined that the*  
32 ~~evidence of fraud or willful misrepresentation is insufficient~~ *no*  
33 *credible allegation of fraud remains against the provider or when*  
34 *legal proceedings relating to the alleged fraud or willful*  
35 ~~misrepresentation the allegation are complete.~~

36 (B) Cite the circumstances under which the ~~withholding of the~~  
37 ~~payments~~ *payment suspension* will be terminated.

38 (C) Specify, when appropriate, the type or types of claims for  
39 which payment is being ~~withheld~~ *suspended.*

(D) Inform the provider of the right to submit written evidence that would be admissible under the administrative adjudication provisions of Chapter 5 (commencing with Section 11500) of Part 1 of Division 3 of Title 2 of the Government Code, for consideration by the department.

~~(3)~~

(b) Notwithstanding Section 100171 of the Health and Safety Code, a provider may appeal a ~~withholding of~~ payment ~~suspension~~ pursuant to Section 14043.65. Payments ~~withheld~~ *suspended* under this section shall not be returned to the provider during the pendency of any appeal and may be offset to satisfy audit or appeal findings.

(c) *A payment suspension may be lifted when a resolution of an investigation for fraud or abuse occurs as defined in subdivision (p) of Section 14043.1.*

(d) *An allegation shall be considered credible if it exhibits indicia of reliability as recognized by state or federal courts or by other law sufficient to meet the constitutional prerequisite to a law enforcement search or seizure of comparable business assets.*

(e) *On a quarterly basis, the Department of Justice, and any other law enforcement agency that has accepted referrals for investigation from the department, shall submit a report to the department listing each referral and stating whether the referral continues to be under investigation and whether it involves a credible allegation of fraud. If the Department of Justice or a law enforcement agency fails to submit a report under this subdivision, the department may request the report from the Department of Justice or the law enforcement agency on no more than a quarterly basis. The Department of Justice or the law enforcement agency, as applicable, shall provide the report within 30 days of the request.*

(f) *A report, request, or notification submitted under this section shall be exempt from the California Public Records Act (Chapter 3.5 (commencing with Section 6250) of Division 7 of Title 1 of the Government Code). These records may be disclosed to law enforcement agencies or other government entities that execute an agreement conforming to subdivision (e) of Section 6254.5 of the Government Code.*

(g) *For purposes of this section, all of the following apply:*

(1) “Provider” has the same meaning as that term is defined in Section 14043.1

(2) “Good cause exception” means a reason determined by the department that falls under Section 455.23(e) or (f) of Title 42 of the Code of Federal Regulations.

(3) “Law enforcement agency” includes any agency employing peace officers, as defined in Chapter 4.5 (commencing with Section 830) of Title 3 of Part 2 of the Penal Code.

~~(b)~~

(h) The director may, in consultation with interested parties, adopt regulations to implement this section as necessary. These regulations may be adopted as emergency regulations in accordance with the Administrative Procedure Act (Chapter 3.5 (commencing with Section 11340) Part 1 of Division 3 of Title 2 of the Government Code) and the adoption of the regulations shall be deemed to be an emergency and necessary for the immediate preservation of the public peace, health and safety, or general welfare. The director shall transmit these emergency regulations directly to the Secretary of State for filing and the regulations shall become effective immediately upon filing. Upon completion of the formal regulation adoption process and prior to the expiration of the 120-day duration period of emergency regulations, the director shall transmit directly to the Secretary of State the adopted regulations, the rulemaking file, and the certification of compliance as required by subdivision (e) of Section 11346.1 of the Government Code.

~~(e) For purposes of this section, “provider” means any individual, partnership, group, association, corporation, institution, or entity, and the officers, directors, employees, or agents thereof, that provide services, goods, supplies, or merchandise, directly or indirectly, to a Medi-Cal beneficiary, and that has been enrolled in the Medi-Cal program.~~

SEC. 25. Section 14123.05 of the Welfare and Institutions Code is amended to read:

14123.05. The department shall develop, in consultation with provider representatives, including, but not limited to, physician, pharmacy, and medical supplies providers, a process that enables a provider to meet and confer with the appropriate department officials ~~within 30 days~~ after the issuance of a letter notifying the provider of a temporary withhold of payments *payment suspension*,

1 pursuant to Section 14107.11, or a temporary suspension, pursuant  
2 to subdivision (a) of Section 14043.36, for the purpose of  
3 presenting and discussing information and evidence that may  
4 impact the department's decision to modify or terminate the  
5 sanction.

6 SEC. 26. Section 14409 of the Welfare and Institutions Code  
7 is amended to read:

8 14409. (a) No prepaid health plan, marketing representative,  
9 or marketing organization shall in any manner misrepresent itself,  
10 the plans it represents, or the Medi-Cal program or Healthy  
11 Families Program. Violations of this section shall include, but are  
12 not limited to:

13 (1) False or misleading claims that marketing representatives  
14 are employees or representatives of the state, county, or anyone  
15 other than the prepaid health plan or the organization by whom  
16 they are reimbursed.

17 (2) False or misleading claims that the prepaid health plan is  
18 recommended or endorsed by any state or county agency, or by  
19 any other organization which has not certified its endorsement in  
20 writing to the prepaid health plan.

21 (3) False or misleading claims that the state or county  
22 recommends that a Medi-Cal beneficiary enroll in a prepaid health  
23 plan.

24 (4) Claims that a Medi-Cal beneficiary will lose his benefits  
25 under the Medi-Cal program or any other health or welfare benefits  
26 to which he is legally entitled, if he does not enroll in a prepaid  
27 health plan.

28 (b) Violations of this article or regulations adopted by the  
29 department pursuant to this article shall result in one or more of  
30 the following sanctions that are appropriate to the specific violation,  
31 considering the nature of the offense and frequency of occurrence  
32 within the prepaid health plan:

33 (1) Revocation of one or more permitted methods of marketing.

34 (2) Termination of authorization for a plan to provide application  
35 assistance.

36 (3) Refusal of the department to accept new enrollments for a  
37 period specified by the department.

38 (4) Refusal of the department to accept enrollments submitted  
39 by a marketing representative or organization.

1 (5) Forfeiture by the plan of all or part of the capitation payments  
2 for persons enrolled as a result of such violations.

3 (6) Requirement that the prepaid health plan in violation of this  
4 article personally contact each enrollee enrolled to explain the  
5 nature of the violation and inform the enrollee of his right to  
6 disenroll.

7 (7) Application of sanctions as provided in Section 14304.

8 (8) Temporarily ~~withhold~~ *suspend* capitation payments for  
9 beneficiaries enrolled in violation of this article, or regulations  
10 adopted thereunder, until the prepaid health plan is in substantial  
11 compliance with the statutory and regulatory provisions.

12 (c) Any marketing representative who violates subdivision (a)  
13 while engaged in door-to-door solicitation is guilty of a  
14 misdemeanor, and shall be subject to a fine of five hundred dollars  
15 (\$500) or imprisonment in the county jail for six months, or both.

16 SEC. 27. If the Commission on State Mandates determines  
17 that this act contains costs mandated by the state, reimbursement  
18 to local agencies and school districts for those costs shall be made  
19 pursuant to Part 7 (commencing with Section 17500) of Division  
20 4 of Title 2 of the Government Code.